

# *Being the Good Samaritan:*

Health Care Access for All Californians



A study guide for congregations

California Council of Churches

Second Edition, 2008

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### **California Council of Churches**

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*www.newmoongraphics.com*

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A note about form and content. This study guide directs the user to resources available on the Internet. Doing this accomplishes two primary goals: 1) It allows us to keep our study resources updated and current over the lifespan of the issue being studied – usually several years. 2) It helps us to be good stewards of our financial resources by keeping printing and mailing costs in check. If your congregation does not have access to the Internet, please be in touch with the California Council of Churches at (916) 488-7300 and we will assist you in obtaining resource materials by fax or mail.

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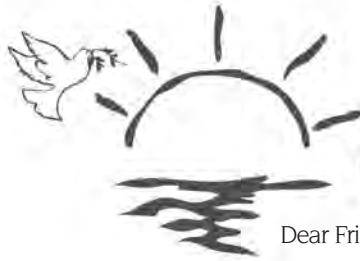
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Letter from the Executive Director



# California Council of CHURCHES

Dear Friends in the California Faith Community:

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info@calchurches.org  
www.calchurches.org

Today, almost seven million Californians lack health care insurance, out of a population approaching 37 million. These are individuals and families that work hard, play by the rules, and pay their taxes, yet don't get basic health care coverage.

The Rev. Dr. Rick Schlosser  
*Executive Director*

We know that the uninsured live sicker and die younger. We know that most uninsured families are one medical emergency away from financial ruin. And, we know that all Californians are impacted by the health care crisis.

Elizabeth Sholes  
*Director of Public Policy*

As people of faith committed to social and economic justice for all people, especially those most vulnerable in our society, we have an obligation to educate our faith communities on the issues around health care. We have an opportunity to influence this crisis by being prepared to roll up our sleeves for the hard work of advocacy.

The Rev. Gail Benson  
*Southern California  
Health Care Director*

- African Methodist Episcopal Church
- African Methodist Episcopal Zion Church
- American Baptist Churches of the West
- Armenian Church of America
- Christian Methodist Episcopal Church
- Churches of the Brethren
- Christian Church (Disciples of Christ)
- Community of Christ
- The Episcopal Church
- Ethiopian Orthodox Church
- Evangelical Lutheran Church in America
- Greek Orthodox Church
- Independent Catholic Churches International
- Metropolitan Community Church
- Moravian Church in America
- National Baptist Convention
- Presbyterian Church (U.S.A.)
- Reformed Church in America
- Swedenborgian Church
- United Church of Christ
- United Methodist Church
- Church Women United
- Orthodox Clergy Council

Much has changed since the first edition of this study guide was published in 2005; and much has remained the same. We've updated the information, details, content, and resources. However, if anything, the crisis is more serious now for millions of Californians than it was even three years ago. Clearly, our work is as important as ever.

Training on leading this study in your congregation and follow-up training on how to be an effective advocate in the public policy arena are available from the California Council of Churches. In Southern California, contact the Rev. Gail Benson (gail@calchurches.org) and, in Northern California, contact Elizabeth Sholes (sholes@calchurches.org).

I pray you and your congregation will join us by using this study guide and related resources to engage people of faith in education and ongoing advocacy work to provide health care for all Californians.

Sincerely,

Rev. Dr. Rick Schlosser  
Executive Director  
www.calchurches.org/health



## Introduction

In 1994 the California Council of Churches, with support from the James Irvine Foundation and numerous denominational sources, developed a comprehensive health care education project titled *A Vision of Wholeness: Responding to America's Health Care Crises*. The project emerged as a response to the health care reform debate that was echoing in the halls of Congress during those years. The results of that debate were painful for many and ultimately left the health care system in disarray. In 1994 the estimated number of Americans without health insurance was 38.5 million. Today it is 47 million and steadily increasing.

At the end of the first decade of the 21st century, we remain with the same questions and challenges. Are there new answers or new solutions or even new questions? Why has universal access to health care proven so difficult to enact? The answers to these questions are complex, but not impossible to understand. With support from The California Endowment and The California Wellness Foundation, the California Council of Churches invites the faith community to engage in a process of moral deliberation as health care access policy discussions reach new levels of compelling interest in our state and in our nation.

As you begin to study legislative proposals and system designs, you will start where people of faith must always begin — by asking, “What is God calling me to do? What underlying values are held up when thoughtful people struggle together around this issue? What does a just, accessible health care system that will serve *all* God’s children look like?”

This study guide, along with the project website at [www.calchurches.org/health](http://www.calchurches.org/health), has been developed to assist in formulating personal and corporate answers to these questions, as well as to offer some of the tools needed to understand both the history of health care insurance coverage in the United States and new health care models that are emerging from the ongoing conversations.

***Welcome to the journey!***

### **Luke 10:30-34**

*“A man was going down from Jerusalem to Jericho, and fell into the hands of robbers, who stripped him, beat him, and went away, leaving him half dead. Now by chance a priest was going down that road; and when he saw him, he passed by on the other side. But a Samaritan while traveling came near him; and when he saw him, he was moved with pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him.”*



## Tips for Effective Discussion Leadership

*Courtesy of the Study Circles Resource Center*

### 1. Be prepared.

The leader does not need to be an expert (or even the most knowledgeable person in the group) on the topic being discussed, but should be the best prepared for the discussion. This means understanding the goals of the adult forum, familiarity with the subject, thinking ahead of time about the directions in which the discussion might go, and preparation of discussion questions to aid the group in considering the subject. Solid preparation will enable you to give your full attention to group dynamics and to what individuals in the group are saying.

### 2. Set a relaxed and open tone.

- Welcome everyone and create a friendly and relaxed atmosphere.
- Well-placed humor is always welcome and helps people focus on ideas rather than personalities.

### 3. Establish clear guidelines for the discussion.

- At the beginning of the session, establish the guidelines and ask participants if they agree to them or want to add anything:
- All group members are encouraged to express and reflect on their honest opinions.
- All views should be respected.
- Though disagreement and conflict about ideas can be useful, disagreements should not be personalized. Put-downs, name-calling, labeling, or personal attacks will not be tolerated.
- It is important to hear from everyone. People who tend to speak a lot in groups should make special efforts to allow others the same opportunity.
- The role of the leader is to remain neutral and to guide conversation according to the ground rules.

### 4. Stay aware of and assist the group process.

- Always use your “third-eye”; you are not only helping to keep the group focused on the content of the discussion, but you will be monitoring how well the participants are communicating with each other – who has spoken, who hasn’t spoken, and whose points haven’t yet received a fair hearing.
- Consider splitting up into smaller groups to examine a variety of viewpoints or to give people a chance to talk more easily about their personal connection to the issue.
- When wrestling with when to intervene, err on the side of non-intervention.
- Don’t talk after each comment or answer every question; allow participants to respond directly to each other. The most effective leaders often say little, but reflect on how to move the group toward its goals.

- Don't be afraid of silence. It sometimes takes a while for someone to offer an answer to a question you pose.
- Don't let anyone dominate; try to involve everyone.
- Remember: a forum is not a debate but a group dialogue. If participants forget this, don't hesitate to ask the group to help re-establish the guidelines.

### **5. Help the group grapple with content.**

- Make sure the group considers a wide range of views. Ask the group to think about the advantages and disadvantages of different ways of looking at an issue or solving a problem. In this way, the trade-offs involved in making tough choices become apparent.
- Ask participants to think about the concerns and values that underlie their beliefs.
- Don't allow the group to focus on or be overly influenced by one particular personal experience or anecdote.
- Either summarize the discussion occasionally or encourage group members to do so.
- Remain neutral about content and be cautious about expressing your own values.
- Help participants to identify "common ground" but don't try to force consensus.

### **6. Use questions to help make the discussion more productive.**

Some useful discussion questions:

- What seems to be the key point here?
- What is the crux of your disagreement?
- Does anyone want to add to (or support, or challenge) that point?
- Could you help us understand the reasons behind your opinion?
- What experiences or beliefs might lead people of faith to support that point of view?

### **7. Reserve adequate time for closing the discussion.**

- Ask the group for last comments and thoughts about the subject.
- You may wish to ask participants to share any new ideas or thoughts they've had as a result of the discussion.
- If you will be meeting again, remind the group of the readings and subject for the next session.
- Thank everyone for their contributions.
- Provide some time for the group to evaluate the group process.



### Discussion Guidelines

*Courtesy of the Study Circles Resource Center*

- ✓ Share your concerns and beliefs.
- ✓ Listen carefully to others.
- ✓ Be willing to examine your own beliefs in light of what others say.
- ✓ Speak your mind freely, and strive to maintain an open mind.
- ✓ Strive to understand the values and ideas of those who see things differently from you.
- ✓ Cooperate with the leaders to keep the discussion on track.
- ✓ Be sure that everyone has equal time to share their ideas.
- ✓ Address remarks to the group and not an individual.
- ✓ Communicate your needs to the leaders.
- ✓ Value your own experience and opinions.
- ✓ It is OK to disagree.
- ✓ Humor and a pleasant manner can go far in helping you make your points. They help everyone to remember that disagreement is not personal. When we disagree in this dialogue, we disagree about values or ideas, not about individuals or personalities.

Too often our people “perish for the lack of knowledge” about health. With this strategic approach, congregations can embrace local communities and address issues of health with local solutions. [Our] Strategic Plan enables us to monitor progress and pinpoint those strategies, programs or services that work to close the gap in health disparities for African Americans.

Individual health is inseparably linked to community health. The health of every community where there is an AME church determines the overall health of our congregation. A healthy community and healthy church is one that can identify their own problems, implement their own solutions, and capitalize on the strengths of their people. Working together, we can improve the health and well-being of individuals, families, and communities. With your leadership and commitment, we can make a difference and close the disparity gap for African Americans in South Carolina. We must all work together to make this Strategic Plan a reality.



Bishop Henry A. Belin, Jr., Presiding Prelate (retired)  
Seventh Episcopal District of the African Methodist Episcopal Church  
[www.health-e-ame.com/strat1.pdf](http://www.health-e-ame.com/strat1.pdf)



## Notes for Leaders on Using this Study Guide

Copies of all materials needed for handouts in the study sessions are available on the project website [www.calchurches.org/health](http://www.calchurches.org/health). You can reach this site directly or through a link on the California Council of Churches website [www.calchurches.org](http://www.calchurches.org).

As this study guide is being prepared for publication it is clear that the debate over access to health care will continue for some time. By using the website to provide handouts we will be able to continually update the materials and give you the latest information on proposed legislative solutions.

In addition, the list of resources at the back of the study guide contains numerous websites for denominational resources as well as suggestions for other organizations, primarily faith-based, working on access to health care. You are urged to go to the website for your denomination to access their resources for study and relevant social statements and teachings on health.



Photo: Jerry Berndt

- The study guide contains detailed directions for conducting four, one-hour sessions for adults.
- Each session contains “homework” assignments for participants to do individually between group sessions.
- All of the sessions utilize handouts that will need to be copied in preparation for each session or can be accessed by participants from the website.

- If photocopying handouts and assignments, only the group leader(s) need a print copy of this study guide.
- A PDF version of this study guide is available for free on the Health Care page of our website at [www.calchurches.org](http://www.calchurches.org)

## Session One – Health Care is in Crisis

### Objectives:

- Gain a basic understanding of the current state of health care access in California and the United States.
- Reflect on the health care crisis as a spiritual crisis.



### Leader Preparation:

- Read through all session materials.
- Research session updates and additional resources at [www.calchurches.org/health](http://www.calchurches.org/health).
- Familiarize yourself with **Tips for Effective Discussion Leadership** (page 4) and **Discussion Guidelines** (page 6).
- Tape up three pieces of newsprint in the room. The heading for the first is “Surprises.” The second heading is “Learnings.” The third is “Questions.”
- Check meeting space for adequate seating and set up. Placing chairs in a circle is usually the most effective format for discussions.
- Materials for handouts may be copied from the discussion guide or downloaded from the project website [www.calchurches.org/health](http://www.calchurches.org/health).



Photo: Jerry Berndt

### Materials Needed:

- Copies of **Discussion Guidelines** (page 6)
- Copies of **Pop Quiz on Health Care Access**
- Copies of handout **Symptoms of our Current Health Care Crisis**
- Bibles for each participant or copies of John 15:12-17 and Luke 10:30-34
- Copies of handout **Background Reading Material for Session Two**

## Session Outline

### Introduction

The United States is the only industrialized nation in the world that does not have some form of universal health insurance. Not long ago, we shared this not-very-noble distinction with South Africa. Now we stand alone.

Oddly, the United States spends more on health care than any other nation (\$7,439 per capita in 2007). The universal, single payer health care systems in Canada and Europe cost about half of what we pay here. We intentionally support national health insurance for Americans who are over the age of sixty-five. Many of our hospitals use expensive, sophisticated equipment in diagnosing and treating our pathologies. Individuals and families who are well-insured receive services that are as good — and, in many cases, far better — than elsewhere in the world.

In 2000, the World Health Organization (WHO) ranked the U.S. 37th in the world in responsiveness and cost and 72nd in overall outcomes. The CIA World Factbook ranks the U.S. 41st in infant mortality and 45th in life expectancy. Virtually everyone agrees, however, that our health care system, especially the way Americans are provided with health insurance — is desperately in need of reform. The system has become a sick patient in need of surgery.

- 10 minutes      Gathering and Opening Reflection. Invite a participant to read Luke 10:30-34. Invite participants to introduce themselves and answer question: “What role do you/have you play(ed) in the current health care system – consumer, nurse, insurance broker, employer, physician, family care-giver, etc.?”
- 5 minutes      Distribute copies of Discussion Guidelines (Page 6) and answer any questions. Share any needed logistical information regarding the study schedule and materials.
- 15 minutes      Distribute copies of Pop Quiz on Health Care. Give people just 3-5 minutes to complete the quiz. When everyone is done, correct the quizzes together. Read the answers (found on Page 39.) Ask participants if there were any surprises, learnings or questions for them in this exercise. Write any comments on the appropriate newsprint.
- 20 minutes      Distribute copies of handout Symptoms of our Current Health Insurance Crisis. Ask participants to get into groups of 2-3 people. Take a few minutes to read the handout. Then ask participants to discuss the following questions:
- We began the session with reading the parable of the Good Samaritan. How does this story relate to the experience of the uninsured today?
  - What are some other consequences of being uninsured?
  - What has been your experience with the current health care system? Has someone in your family, or perhaps you yourself, been uninsured or had difficulty accessing medical care?
- Ask participants to return to large group. Invite them to share comments/highlights from their discussions. Add comments to sheets of newsprint where appropriate – surprises, learnings, questions.
- 5 minutes      Leader summarizes highlights from discussions using comments recorded on newsprint. Distribute copies of Background Reading Material for Session Two.

### **PARTICIPANTS WILL NEED TO READ THIS MATERIAL PRIOR TO THE NEXT SESSION.**

- 5 minutes      Closing. Leader read John 15:12-17. Invite participants to reflect on this text during the week as they read the materials for the next session.

### California Council of Churches

#### POP QUIZ ON HEALTH CARE ACCESS

- About how many Americans have no health coverage whatsoever—not even government-sponsored coverage for the poor?  
 25 million    30 million    35 million    40 million    45 million
- About how many Americans have no health coverage whatsoever—not even government-sponsored coverage for the poor?  
 27 million    32 million    37 million    42 million    47 million
- In California, what percentage of the population is uninsured?  
 12%    16%    20%    26%    32%
- What percent of uninsured people in the United States belong to minority populations (for example, Hispanic, African-American, Asian-Pacific)?  
 25%    50%    75%    90%
- How less likely are uninsured children to receive medical care for common childhood illnesses (e.g. ear infections) than are children who are insured?  
 40%    50%    60%    70%
- How many uninsured children in the U.S. have parents who work in a small business?  
 350,000    450,000    550,000    650,000
- What percent of uninsured Americans are in working families?  
 20%    40%    60%    80+%
- What percent of insured Americans receive their coverage through their workplace?  
 20%    30%    40%    50%    60%
- What percent of American employers do not offer health coverage to their employees?  
 One-third    One-half    Two-thirds
- What percentage of uninsured workers are employed by firms that do not offer health coverage?  
 One-third    One-half    Two-thirds
- During the last decade, the average employee premium contribution to his/her health insurance has increased by what percent?  
 10%    25%    50%    75%    90%
- About what percentage of bankruptcies in the United States are directly related to unpaid medical bills?  
 20%    30%    40%    50%    60%
- Emergency rooms play a large role in meeting the medical needs of the uninsured. During the past decade, what percent of emergency rooms in California have closed?  
 5%    10%    15%    20%    25%



## California Council of Churches

### HANDOUT

### Symptoms of Our Current Health Care Crisis<sup>1</sup>

#### Who Is Uninsured?

About 47 million people in the United States do not have health insurance and this number continues to rise every year. In addition, another 30 million Americans under 65 are without health insurance for some period of time every year. In California, nearly seven million people – that’s close to one in every five Californians – find themselves shut out of the system. That’s a group equal in size to the combined populations of our three largest cities (Los Angeles, San Diego and San Jose) with most of San Francisco included as well.

Contrary to popular opinion, the largest number of the uninsured is employed in our nation’s workforce. In fact, eight of ten Americans who are uninsured come from working families. Their jobs tend to be in service industries and in small firms, which are less likely to offer coverage to their employees.

Compared to the population at large, the uninsured tend to be younger, to have lower incomes, and to have fewer years of education. In 2007, about 30% of America’s working uninsured families received incomes under the federal poverty level, which in 2008 is \$21,200 for a family of four.

Each year large numbers of Americans lose their health insurance or experience cutbacks in the services covered by their plans. In the face of rising costs, employers often discontinue health plans that, in some cases, they have offered for years. Alternatively, they transfer increased costs to employees by raising premium contributions and or by increasing co-payments.



Photo: Jerry Berndt

1. Statistical information about insured, under-insured, and uninsured Americans that is cited throughout this session is largely, but not entirely, drawn from “Health Coverage in America”, published each year by the Alliance for Health Reform. This report includes extensive footnotes. It is available at [www.allhealth.org](http://www.allhealth.org)

### What are Consequences of Being Uninsured?

According to a report published by the Institute of Medicine,<sup>2</sup> Americans without health insurance are more likely to:

- *Receive too little medical service and receive it too late.* They receive fewer diagnostic services. For example, they often forgo cancer and diabetes screening tests. They do not receive services that are recommended for chronic diseases. They lack regular access to medications. 43% of those without health insurance are between the ages of 50-65. If the lack of health insurance was a disease, it would be the third highest cause of death in this age group. An estimated 18,000 Americans die prematurely as a result of their lack of health insurance (Institute of Medicine, 2008, [www.iom.edu](http://www.iom.edu)).
- *Be sicker and die sooner.* Children in uninsured families, for example, are about 70% less likely to be treated for common childhood diseases such as asthma, ear infections, and sore throats. Left alone, many of these diseases worsen, often leading to more severe consequences. Adults without health insurance experience greater declines in the quality of their general health. Changes often included spiking and uncontrolled blood pressure, decreased ability to walk or to climb stairs, and a reduced ability to perform daily activities. Collectively, they tend to die sooner than insured adults. For example, when they are dealing with heart attacks, cancer, traumatic injury, and HIV infection, uninsured adults face a 25% higher risk of dying.
- *Receive poorer care when they are in the hospital even for acute situations such as a motor vehicle crash.* They often do not receive needed services. They regularly receive lower quality care. They have a greater risk of dying in the hospital or shortly after their discharge.

As is widely recognized, the uninsured and the under-insured often seek medical services at hospital emergency rooms. Their only medical care comes from a trip to the emergency room. Treatment in these facilities is extraordinarily expensive, and the state's health care budget is strained as taxpayers ultimately pay the cost for indigent patients who have no alternative other than to seek health care there. Emergency rooms are chronically overloaded. Depending on times and places, waiting lines are long. Illnesses that could have been prevented by insurance-covered visits to physicians are in danger of running out of control before the uninsured seek help in emergency rooms. Patients are often much sicker when they arrive in the ER because they have waited until their condition became critical.

In California, ERs all over the state are overcrowded, understaffed and going out of business. Since 1990, 15 percent of California's emergency rooms have shut their doors, unable to make the numbers work. Even people with insurance may arrive at an ER only to find its doors closed.

2. You can read this report at [http://www.usc.edu/crcr/health/coverage/care\\_wo\\_coverage.pdf](http://www.usc.edu/crcr/health/coverage/care_wo_coverage.pdf) or [www.iom.edu/CMS/3809/4660/4333.aspx](http://www.iom.edu/CMS/3809/4660/4333.aspx)



### What Does this Mean for Me?

A health care system works well only when it connects everyone, thereby spreading the risk pool across the broadest possible population. It is a problem that can be solved only by everyone working together. Research shows that coverage for all citizens of the state – with everyone paying at least something for care – would likely result in lower premiums for all of us. How? One example: if everyone had access to affordable and basic preventative care, the cost of emergency room treatments directly correlated to undiagnosed conditions would decline.



Photo: Jerry Berndt

It helps to think about this problem in terms we can all understand. The nation's public utility system is a good analogy. I can have the most sophisticated electrical circuitry and the brightest front porch lights of anyone in my entire town. However, if the public utilities system only reaches a portion of my town, chances are I will pay a higher price for my electricity than if it reached everyone. Why? The utility infrastructure has been created for the public good, but if not everyone shares in its cost – and benefit – then I will end up paying a disproportionate share of the cost of electricity. The system is only truly functional when everyone is participating.

Additionally, even those with health insurance are in precarious positions under our current system. An unexpected job loss, divorce, death of a spouse can all end coverage that has been taken for granted. Young people who have been covered on their parent's policy are no longer eligible when they turn 18. Single-parent households with young adult children in college are often faced with a choice of paying for coverage for their children or for themselves. They cannot afford both.

Increasingly, employers are choosing not to hire additional people because of increased health insurance costs, which have risen at a rate of 22% per year in some areas of the US. As some employers have noted, their health care costs have risen at three to four times the rate of increase of their revenues. In addition, more companies are requiring their workers to pay larger and larger co-pays and deductibles for the same or inferior health care, and many no longer provide health care coverage for dependents.

The VEBA (Voluntary Employee Beneficiary Associations) recently negotiated by the United Auto Workers indicate a trend toward the dismantling of America's historic employer-based health care system. America's largest corporations are increasingly stepping away from their commitment to provide health care for their workers, underscoring the need for us to seek new solutions.

Finally, recent trends at both the Federal level and here in California are for reducing government commitment to the Medicaid and MediCal programs that serve the poor. Many who have depended on these plans in the past are now becoming ineligible due to stricter paperwork requirements, or may be unable to find a health care provider due to declining reimbursement rates.

### California Council of Churches

#### HANDOUT

#### Background Reading Material for Session Two

#### Why do California's religious communities have an important role to play in addressing our state's and nation's health care problems?

When pollsters approach Americans to measure their attitudes toward the uninsured, they discover a variety of reasons why Americans are reluctant to take bold steps in reforming their health insurance system. For example:

- A majority of Americans believe that the uninsured can find needed medical services in hospital emergency rooms. They are unaware of skyrocketing costs for serving the uninsured in this way, and they are unaware that, as taxpayers, they themselves are covering many of these costs. In addition, patients with no insurance are billed at two to four times the rate paid by insurance companies for covered patients. Small wonder that over 50% of personal bankruptcies in the U.S. are caused by medical bills!
- Although Americans say they want to find help for the uninsured, they are unsure about raising taxes to create a universal health care insurance system (a 2008 Public Policy Institute of California poll found the public evenly divided on this question). They are unaware that the total cost of a universal health insurance system would be less than what is currently being paid for a system that leaves many Americans out.

Bruce Vladeck, Professor of Health Policy at New York's Mount Sinai University, is correct when he argues that these poll numbers translate into a spiritual problem.<sup>3</sup> Our nation's religious communities have an obligation to join the debate about health insurance reform. They are already involved in the debate, mainly because religious attitudes—both examined and unexamined—have created barriers to reform.

For a host of complicated reasons, Vladeck says, “religious groups that want to infuse religious values into politics are often opposed to using legislation to expand health insurance coverage. Religious communities whose theologies urge the expansion of ‘health care justice’ have often been reluctant to join the fray. That is why America's religious communities should examine their theological stances in light of our growing health coverage crisis. The debate needs fresh air. It needs to be made far more visible in our week-to-week congregational life.”

California's religious communities have a special obligation. California has greater insurance coverage problems than the rest of the nation. Approximately one-sixth of the nation's uninsured lives in California. In Los Angeles County, which is the epicenter of the national insurance coverage crisis, over two million residents (25% of the non-elderly population) are uninsured at some time during each year. And, Hispanics and African-Americans are disproportionately represented in these numbers.

3. Bruce Vladeck, “Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future,” *American Journal of Public Health*, January, 2003, Vol. 93, no. 1, pp.16-19.





## A Faith Based Response

While religious traditions vary somewhat on the values which undergird a faith-based response to our health care crisis, five overarching themes have emerged from our community of faith. The values expressed below are not an exhaustive list, but they are representative of the perspectives with which the faith community has approached the problems of providing access to health care for all.

1. Health care delivery is a ministry
2. Every human person has inherent dignity
3. Individual needs are to be balanced by the common good
4. The demand for social justice focuses our attention on the most vulnerable
5. Responsible stewardship is an important aspect of providing health care

### 1. Health Care Delivery is a Ministry

Our motive for the provision of health care stems from our faith commitment. Helping those who are ill and dying expresses love of God and neighbor.

*Because the scriptural test of a just nation is how it treats its weakest members (Micah 6:8; Amos 5:24; Jeremiah 5:26-29), we will be clear and consistent advocates to policy-makers on behalf of public health matters and access to healthcare for everyone. We join other faith-based communities in urging our government to establish policy for a system of healthcare in which everyone, everywhere in the United States has access to basic, affordable healthcare, and where the risks and expenses are shared by all.*

— Mennonite Church USA, 2006

If we believe that health care delivery is a ministry, one important consequence is that it can never be simply a business. Because a health care delivery system serves the unpredictable needs of individuals and communities, it is a public good, a community service. For too long, the health care delivery system has been reduced to a mere commodity produced and exchanged for a profit.

Because of its inherent complexity, contemporary health care must be organized and delivered in a business-like fashion, but it is always something more than the sale of techniques, motivated by potential profit. It is service to persons in need.

### 2. Health Care and Human Dignity

Each person, created by God, is endowed with a transcendent value that cannot be reduced to a price. Unlike the relative value of commodities, each human person has a spiritual worth that is absolute and intrinsic. Because of this inherent dignity, no price can be affixed to health care nor can some individuals be ranked as more or less important than others.

These claims create an important critical perspective on the present system. Millions have no health insurance. A system of long-term care that assures assistance for those who need help with daily living does not exist. The system of delivery is fragmented and provider-centered. Too often patients are seen not as persons of intrinsic value with health care needs but as opportunities for reimbursement or as threats of malpractice litigation.

*“From the earliest passages of the Bible (Genesis 15:26), Christians recognize that it is ultimately God who heals, and in the New Testament Jesus’ healing ministry is intended to demonstrate the presence of God. Claiming the promise of God, the United Methodist Social Principles (§162, T) therefore recognize that ‘health care is a basic right’ rather than a commodity available only to those with means, and recognizes ‘the role of governments in ensuring that each individual has access to those elements necessary to good health.’”*

— *The General Board of Church and Society, United Methodist Church  
“Universal Health Care in the United States of America”, adopted October 2001*

### 3. Health Care and the Common Good

The faith community places the dignity of each person in its proper social context. While each person is divinely created, the human person is inherently social. Each of us relies on the care and support of those around us and is able to work and thrive only because of the efforts of others around us and of generations who have gone before. None of us is an island. We are dependent on the whole community.

*“Health is central to our well-being, vital to relationships, and helps us live out our vocations in family, work and community. Caring for one’s own health is a matter of human necessity and good stewardship. Caring for the health of others expresses both love for our neighbor and responsibility for a just society. As a personal and social responsibility health care is a shared endeavor.”*

— *“Caring For Health: Our Shared Endeavor,” Evangelical Lutheran Church in America 2003*

Our current health care system places little value on the community. States resist sharing each other’s health care burdens. Insured groups and individuals reject the claims of outsiders for health insurance, pointing to their high risks or, in some cases, “irresponsible” lifestyles. The moral framework of health insurance – that the financial risks of illness should be spread as widely as possible across a community – has been destroyed. Insurers have segmented the market place, providing low cost insurance to the healthy and pricing the sick out of reach. Patterns of lack of insurance, barriers in access to health care, and cost shifting are markers that reflect a breakdown of a sense of national community, and increasingly *de facto* discrimination against the uninsured – increasingly the working poor.

### 4. Health Care and Social Justice

One of the dominating themes of the Hebrew Scriptures is the demand for social justice.

*“Why then is not the health of my poor people restored?” Jeremiah 8:22*

The prophets of the Hebrew Scriptures insisted that societies be judged on how they care for their least well off such as widows, orphans, and those who are marginalized. In the Christian tradition, the ministry of Jesus shows a similar commitment to see justice from the side of the poor and powerless.

Those of low socioeconomic status, members of minority racial and ethnic groups, individuals who have had catastrophic illnesses, those needing chronic care services, and millions of children are significantly underserved by the present health care system.

*"The health of a society is measured in a very important way by the quality of its concern and care for the health of its people. How provision is made for children in the dawn of life, the elderly in the twilight of life, and the sick, needy, and those with disabling conditions in the shadow of life are clear indices of the moral character and commitment of a nation ... We are painfully aware that (the) vision of health for all is not a reality in our communities, in our nation, or in the world we are called to serve in Christ's name."*

*"Life Abundant: Values, Choices, and Health Care: The Responsibility and Role of the Presbyterian Church (U.S.A.)," 1988 General Assembly*

### 5. Health Care and Stewardship

The faith community asserts that the natural world is created by God and given as a gift to all. Human beings have dominion over creation, not in the sense of domination but in the sense of responsible stewardship. This entails an obligation to use natural and social resources wisely and on behalf of all. Waste and excess, therefore, are not simply economic flaws or failures; they are offenses against responsible behavior and acts of ingratitude for the gift of creation. Health care providers, both private and public, have an obligation to use resources prudently. Individuals also have a responsibility to be good stewards of their own health out of thankfulness for the gift of life and in order to serve God and neighbor.

Stewardship is a challenging value in a county where health care costs exceed 15% of the Gross National Product (GNP). Public expectations are often unreasonable. Expensive medical technology is developed to cure illness but far too little emphasis is placed on prevention and the public health measures that could avoid illness. With little health care planning at the local level, expensive medical technologies are duplicated and health care facilities expand throughout America's suburbs while they continue to shrink in urban and rural communities. Duplicative administrative costs continue to spiral out of control with current levels reaching 30% of every dollar spent for health care.

*"America spends the most per capita on health care of any industrialized nation, and is the only industrialized nation that does not have national health care. The restrictions of managed care are increasingly distressing to health care professionals and the general public. Even Medicare, America's most important and most successful health insurance program is being threatened. America's health care costs too much, covers too little, and excludes too many."*

*— Universal Health Care Campaign, United Church of Christ*

## Session Two – Values and Health Policy

### Objectives:

- Examine Biblical perspectives on health and healing.
- Reflect on the relationship between values held as members of a community of faith and the current realities of access to health care.



Photo: Jerry Berndt

### Leader Preparation:

- Read through all session materials.
- Research session updates and additional resources at [www.calchurches.org/health](http://www.calchurches.org/health).
- Familiarize yourself with Tips for Effective Discussion Leadership (page 4) and Discussion Guidelines (page 6).
- Prepare large piece of paper on flip chart or board with title “Values Concerning Health Care.”
- Check meeting space for adequate seating and set up. Placing chairs in a circle is usually the most effective format for discussions.



Photo: Jerry Berndt

**Planning ahead for Session Three:** Prepare handouts from the Physicians for a National Health Program at [http://www.pnhp.org/facts/single\\_payer\\_resources.php](http://www.pnhp.org/facts/single_payer_resources.php) **AND/OR** secure copies of the 2007 Michael Moore DVD “Sicko” and have everyone view it prior to Session 3. They are usually available at local video outlets, or may be ordered at [www.guaranteedhealthcare.org](http://www.guaranteedhealthcare.org)

### Materials Needed:

- Bibles for each participant or copies of Luke 10:30-34
- Copies of handout **Unpacking Your Values**
- Copies of handout **Health Care and Values**
- Copies of handout **Sharing Our Stories**

## Session Outline

- 15 minutes Opening prayer and reflection. Leader read Luke 10:30-34. Move the class into small groups of 2-3 for discussion:
- Share reflections on the assigned reading for the past week. What was surprising? Were there any new perspectives?
  - Were there connections between the reading and the text from John 15:12-17?
  - What is the relationship between the reading assignment and the parable of the Good Samaritan? What does the parable tell us about our responsibility for health care?
- Move class back into larger group. Invite each group to share one or two highlights from their conversation with the larger group.
- 10 minutes Distribute copies of handout **Unpacking Your Values**. Invite participants to review the statements and to write their responses as indicated on the sheet. Choose 2 or 3 of the statements and ask participants to share whether they agree or disagree with the statement, and why. Invite class members to share which of the three priorities they ranked as the most important.
- 15 minutes Distribute copies of handout Health Care and Values. Working in small groups, ask participants to go through the reading, section by section and discuss where they agree or disagree on the three “Ethical Dilemmas” presented on the handout. (Note: It is not important to have consensus in the group, only to identify the different points of view represented within each group.)
- 10 minutes Report to the larger group on the perspectives represented in each smaller group. (Rotate small group answers – e.g. listen to one from each group and then start again for second perspective.)
- Record insights on the large sheet of paper labeled “Values Concerning Health Care.”
- 10 minutes Distribute copies of handout **Sharing our Stories**. Ask someone to read the story out loud while others follow along. Invite participants to discuss:
- What does this story say about our values and the health care system? (Add responses as commentary to list of “Values Concerning Health Care.”)
  - What does it say to us as people of faith? Are there connections between this story and the parable?
- 5 minutes Closing and assignments for next session. There is a great deal of information about the issue of health care available on the Internet. This week, go to the project webpage at [www.calchurches.org/health](http://www.calchurches.org/health), and download the document “Health Care Coverage in America: Understanding the Issues and Proposed Solutions.” Read the section titled “How Do Americans Get Health Coverage?” on pages 10 through 17 of this document.

Notes



California Council of Churches

**HANDOUT**  
**Unpacking Your Values**

Read each question and respond using the number that matches most closely how strongly you agree with the statement: 1=Strongly Disagree, 2=Disagree, 3=No Opinion, 4=Agree, 5=Strongly Agree.

- 1. \_\_\_\_\_ Health care is a human right and access to it should be guaranteed to every person in the U.S., regardless of income.
- 2. \_\_\_\_\_ We should rely more on the free enterprise system and less on the government to solve the health care crisis.
- 3. \_\_\_\_\_ Health care financing should be progressive, that it, based on one's ability to pay. Wealthier people should pay more; lower income people should pay less for their coverage and care.
- 4. \_\_\_\_\_ I would prefer to make all my own health care choices and would welcome tax breaks for plans such as individual Health Savings Accounts.
- 5. \_\_\_\_\_ I would be willing to pay higher prices for goods and services if the government required employers to provide health insurance to all their employees.
- 6. \_\_\_\_\_ I want the system I have now. Explain: \_\_\_\_\_  
\_\_\_\_\_
- 7. \_\_\_\_\_ I fear if everybody has health insurance and the same care, mine will be less good and less comprehensive.

In considering proposal to reform the health care system, the most important issue that needs to be addressed is (rank these in order of importance — 1, 2, and 3):

- \_\_\_\_\_ Controlling costs, bringing them in line with inflation.
- \_\_\_\_\_ Preserving the high quality care most well-insured Americans have come to expect (including comprehensive benefits, immediate access to a physician, and the best in medical technology).
- \_\_\_\_\_ Providing access to health care for every American resident.

### California Council of Churches

#### HANDOUT

#### Health Care and Values

#### *Ethical Dilemmas*

One of the reasons Americans have been unable to reach consensus on changing the way health care services are accessed is that we cannot agree on the basic values that should drive our health care system. Is health care a basic human right or a privilege? How should a universal system of health care be financed and administered? What degree of quality can we afford to provide to every person in the United States?

The difficulty comes in our realization that because there will be conflicting goals in any system, trade-offs will be necessary. Painful and difficult choices must be made. Yet, if reform is to be genuine – if it is to result in a truly preferable health care system for all Americans – it must be shaped by the ethical values at stake. What kind of health care system do we want? What basic values will drive it?

#### THREE ETHICAL DILEMMAS

##### 1. Is health care a right or a privilege?

A right is something to which people are entitled simply because they are members of society. Saying that something is a right creates an obligation for others to respect that right. Does society have an obligation to provide health care to all its citizens?

Some Americans would say, “No, there is no right to health care.” A society is obligated to its members, but only to provide access to emergency care, and the United States already does that. A national health care program would be an unreasonable burden on society, they say, and it would require a large role for government at a time when all levels of government are struggling financially. Health care, it is argued, is like a commodity: your ability to have access to it should be based on your ability to pay for it.

On the other hand, those who believe health care is a right suggest that as a rich and blessed society we do have a moral obligation to provide health care to all. In some cases, they argue, life itself is dependent upon access to health care; in many cases, the quality of life is dependent upon that access. According to this argument, ability to pay should not determine access to health care. Furthermore, experience in Canada and Europe indicates that a universal, single-payer health care system reduces paperwork and overhead, with the result that it not only covers everyone but also is more cost-effective and efficient than the care we receive in America now.

Those who believe health care is a right must answer other questions: What is the minimum that society is obligated to provide? How much health care is everyone entitled to? What are the limits of society's responsibility?



## 2. Is health care a private good or a public good?

Should our health care delivery system be treated as a private good and run like a profit-making business, or should it be treated as a public good and run like a government program such as the current health care system for federal employees?

One stream of American political tradition shies away from big government. Historically, there has been a strong notion of individualism in the United States. (Even though pre-industrial America had strong principles of the common good, these were lost — legally and practically — in the 19th century.) Some Americans believe that it is wrong for government to create new social welfare programs, or that government is not qualified to play a managerial role in something as important as health care. They believe that profit-making businesses which focus on efficiency and cost control can best administer our health care system.

Another tradition in American politics is more distrustful of big business than of big government. Many Americans dislike big companies, especially banks and insurance companies, which can be experienced as faceless, self-serving and uncaring. A system that treats health care like a profit-making big business will not work for a public good like health care. Since having a healthy society benefits everyone, the public, through its governmental structures, needs to have control of our health care system.

## 3. Should we limit treatment for some to provide treatment for all?

Rationing in some form exists in every health care system, including our present one. No society is willing to spend enough money to provide all the medical care that everybody needs or wants to stay alive as long as they can. With advances in medical technology, it is now possible to spend enormous sums of money if doctors try every procedure that might work, no matter how slightly it might extend life or how low the probability of success.

In other industrialized nations of the world rationing is up-front and explicit; government officials set guidelines for which illnesses should be treated and how they should be treated (by setting guidelines for which treatments will be paid for.) Doctors then use these regulations to decide what type of treatment a patient should receive.

The fact that more than 15% of Americans have no health insurance is a form of rationing access to the health care system. Most Americans do not think of this as rationing, since it is not the result of an explicit plan. Because of our political culture, explicit rationing may seem less acceptable than the rationing that takes place as the outcome of a system that is largely privately run.

Current health plans already implicitly ration care by policy dollar limits, days of coverage, limits on types of procedures covered. Should we explicitly ration health care under our current system, or should these decisions be made publicly? If we choose to make them publicly, what then are our priorities? Do we want to invest more in research to continue to develop new medical technology or drugs that can save lives? Should maternal and childcare be our top priority? Should we spend more on public health campaigns that emphasize basic health for all?

While we can pursue all of these goals, we cannot accomplish all of them. Choices will have to be made. *What do you believe?*

## **California Council of Churches**

### **HANDOUT**

### **Sharing our Stories**

*Excerpted from materials created for  
Cover the Uninsured Week  
By the Robert Wood Johnson Foundation*

Syed M. Ahmed MD, DrPH  
*Faces of the Uninsured*

*Dr. Syed Ahmed is director of Reach Out of Montgomery County, Ohio and Vice Chairman for Research, Department of Family Medicine and Director, Alliance for Research in Community Health, Wright State University School of Medicine.*



One night about 17 years ago, I was in a car accident not far from my apartment in Houston. I remember lying in the street, my head bleeding, listening to the sirens of the ambulance rushing to the scene. And the only thing I could think was, “How am I going to pay this hospital bill?” I was new to the United States. I had earned my medical degree in my native Bangladesh, and I came here to work on a doctorate degree in public health. As a graduate student, I was barely scraping by, and there was no way I could afford health insurance. So when the rescue workers arrived within minutes of the accident, I literally begged them not to take me to the hospital. I was pretty sure my injuries were minor and I figured, with my medical training, I could patch myself up pretty well. Anything would be better than facing a huge emergency room bill that I couldn’t pay.

The rescue workers, of course, refused my pleas and rushed me to the hospital. As it turned out, my injuries were minor. And ultimately my hospital costs were covered by the auto insurance of the man who caused the car accident. But I didn’t know that until later. And I will never forget that feeling of complete helplessness and panic, knowing I had absolutely no means to pay for my medical care.

I’ve thought of that night often in the last five years, since I’ve volunteered as director of Reach Out of Montgomery County, Ohio. Reach Out brings together a network of volunteer physicians, nurses and others to provide free health care to people who don’t have health insurance. We run clinics two nights a week, for a total of about 40 patient visits each week.

## Sharing our Stories *(continued)*

Nearly all of our patients are working poor who are not offered health coverage through their jobs. Or, if they are offered insurance, they don't make enough to afford the premiums. These are hard-working people, just like any other Americans. Many work in the service industries or they work for small businesses. They're waitresses, lab technicians, schoolteachers. They're working to take care of their families, they're struggling to get by and they do not have health coverage.

Now I've heard some people say 'well, they can always go to the emergency room at the public hospital if they have to.' Well, yes I suppose that is technically true. If someone breaks a bone or is having a heart attack, those are emergencies and they'll go to the ER. But I know from my own experience all those years ago and from talking to my patients: most working people without insurance see the ER as the last resort. From the patients' perspective, they will not go until they absolutely have to.

From a wider economic perspective, it costs the health system millions of dollars every year to pay for uninsured people who wind up in the ER. And from a doctor's perspective, the ER is not the place to attend to chronic diseases, which are by far the most common illnesses in this country.

Every day in the clinics, I see patients who put off getting care for a long time because they can't afford it. We diagnose many, many cases of chronic conditions, such as hypertension and diabetes. Many patients didn't know they had the condition because they hadn't been to a doctor in so long.

Then there are the patients like the woman I saw recently. On her first visit, I diagnosed her with high blood pressure and wrote a prescription for her. When she returned for her follow-up several months later, her blood pressure was even higher. It turns out she had not taken a single pill. She could not afford to pay for the prescription, so she didn't fill it. We scraped and scrambled to find a way to get her the medication because we know if we don't treat her now, it's almost guaranteed we'll be treating her for more serious complications in the future.

We are the richest country in the world and we have a brilliant, technically advanced health care system. But if it doesn't reach all of our citizens, what good does it do? Everyone in this country should have health insurance and access to affordable health care.

I remember that feeling of helplessness when I needed treatment and I knew I couldn't pay for it. It breaks my heart to see my patients struggling with those feelings every week at our clinics.

As a family doctor, I know ignoring an illness never cures one. And I know ignoring the uninsured issue will never cure the problem.

## Session Three – Where Are We Now?

### Objectives:

- Understand the history of health care coverage in the U.S.
- Reflect on the impact of the current system on individual lives.
- Examine the challenges inherent in changing the current system.



### Leader Preparation:

- Prepare handouts from the Physicians for a National Health Program at [http://www.pnhp.org/facts/single\\_payer\\_resources.php](http://www.pnhp.org/facts/single_payer_resources.php) AND/OR secure copies of the 2007 Michael Moore DVD “Sicko” and have everyone view it prior to Session 3. They are usually available at local video outlets, or may be ordered at [www.guaranteedhealthcare.org](http://www.guaranteedhealthcare.org)
- Read through all session materials and/or view the “Sicko” video (if chosen as an option).
- Research session updates and resource materials at [www.calchurches.org/health](http://www.calchurches.org/health).
- Check meeting space for adequate seating and set up. Placing chairs in a circle is usually the most effective format for discussions.



Photo: Jerry Berndt

### Materials Needed:

- Copies of handout *Case Studies – Personal*
- Copies of handout *Case Study – Small Business Owner*
- Copies of handout *Challenges in Reforming U.S. Health Care*

## Session Outline

- 5 minutes Gathering and Opening Prayer. Read Luke 10:30-34.
- 10 minutes Invite participants to share reflections from their assigned viewing of “**Sicko**” or readings from the Physicians for a National Health Program website on Single Payer Resources. What was surprising? Invite participants to share their own experiences in obtaining health coverage. Do they have health insurance? Have they or members of their families ever been without health insurance?
- 15 minutes Distribute copies of Case Studies -- Personal. Invite participants to move into small groups of 2-3. Read the stories and then reflect on how these stories relate to the previous discussions on (1) health care and values and (2) what our religious traditions say about health care.
- 5 minutes Invite each small group to share one or two insights from their conversation.
- 10 minutes Distribute copies of **Case Study – Small Business Owner**. Invite participants to read the story and reflect on challenges for the business community in the health care crisis. Invite participants to share any insights or comments about the story.
- 5 minutes Distribute copies of handout Challenges in Reforming U.S. Health Care. Invite participants to read the handout. As a large group briefly discuss any reactions to the reading.
- 10 minutes Assignment for the next week: Using the reading **Challenges in Reforming U.S. Health Care** as a guide, collect examples of public dialogue about various health care reforms that are being proposed today. These examples can be from the print media – clippings from newspapers and magazines, from Internet research, from television news and commentary, from radio news and commentary or from personal experience such as conversations with family, friends, co- workers, etc. Include denominational websites or publications in your research.

In next week’s session, participants will be asked to share a copy of print articles or written descriptions of audio news/commentaries or conversations. Be sure to note sources of information.

## **California Council of Churches**

### **HANDOUT**

#### **Case Studies – Personal**

Case Study #1: Maureen Adams – Pacoima, California (from [www.covertheuninsuredweek.org](http://www.covertheuninsuredweek.org))

Maureen has a long family history of cancer and because she is uninsured, she has always worried that she wouldn't be able to get the care and screenings that she needed. Maureen lost her health coverage in 1990 after a divorce. She has been employed as a customer service representative for a fitness organization for over 12 years, but her employer does not provide health benefits. She found that she could not afford health insurance in the private market with her income.

Before Maureen began to seek care at Valley Community Clinic, she had not seen a doctor in over 10 years. Each time she had an ache or a pain, she was afraid it was cancer, but was even more afraid of the costs of finding out. While she is currently getting regular screenings at the clinic, Maureen is still anxious at the thought of discovering a serious illness that could land her in serious medical debt.

#### **Questions for Reflection:**

1. What health care policy changes would benefit Maureen?
2. What options does Maureen have for health care? What happens if funding for Valley Community Clinic is reduced?
3. Should working Americans be forced to rely on community clinics for basic preventative health care?



## California Council of Churches

### HANDOUT

#### Case Studies – Personal

Case Study #2: Maria (Story From <http://itsourhealthcare.org/blog1/stories/>)

Maria's husband is employed and has health insurance. However, he also has diabetes, and many of the costs are not covered. To manage his disease, the family is paying \$400 per week in co-pays and out of pocket expenses. Some of his prescriptions cost an additional \$200 per month.

To make matters worse, Maria has no coverage since there is a waiting period for open enrollment on her husband's plan. She has another 3 months to wait before becoming eligible on his policy.

#### Questions for Reflection:

1. Under many plans, large deductibles and co-pays are part of the costs that eat up significant amounts of family income. Under this system, what options do Maria and her husband have?
2. What policy changes would benefit this family? What is the best policy choice for people such as Maria and her husband?
3. With large deductibles and co-pays, much not covered by tax deductions, should insurance in the private market be mandated by the government?



## **California Council of Churches**

### **HANDOUT**

#### **Case Study – Small Business Owner**

Sarita Scarbrough – Houston, Texas (*Story From [www.covertheuninsuredweek.com](http://www.covertheuninsuredweek.com)*)

After serving as a county and city employee, in 1998, Sarita, 35, started her own printing business. She employs 10 workers. She knows from experience how hard it is to start a company and keep it afloat. Unfortunately, she must put the survival of her business ahead of health care coverage.

Sarita cannot afford health insurance for herself or her employees on her company's current earnings. Sarita worries about not having insurance and has used over-the-counter medications without consulting a physician. She is also very concerned about the health and well-being of her employees. She is concerned that one of them may face a serious health problem in the future without the benefit of health care coverage. She worries for them and for her business.

As a small business owner, Sarita must remain competitive by keeping up with the latest advances in printing technology and equipment. Like other small business owners, Sarita markets and looks for new opportunities for growth. Still, she does not always break even every month, and she has determined that providing health care is not economically feasible.

#### **Questions for Reflection:**

1. What options do Sarita's employees currently have for health coverage?
2. If her company was in California, what choices could Sarita make to provide coverage to her employees?
3. What risks does Sarita face by not offering health insurance?



## California Council of Churches

### HANDOUT

#### Challenges in Reforming U.S. Health Care

Excerpted from *"Who Profits from the Healthcare Crisis"*, a paper by the California Nurses Association, January 2007.

- Hospital profits - \$28.9 billion (2005), a record. Hospital revenues, \$544.7 billion. (Modern Healthcare, Dec. 18, 2006).
- Annual research and development spending by the pharmaceutical industry increased by 147% between 1993 and 2004. In the same period, the number of new drug applications to the Food and Drug Administration grew by only 38% and has generally declined since 1999, according to a GAO report (Washington Post, Dec. 20, 2006).
- The 20 largest HMOs in the U.S. made \$10.8 billion in profits in 2005. The top seven U.S. health insurers made a combined \$10 billion, nearly triple their profits of five years earlier. 12 top HMO executives pocketed \$222.6 million in direct compensation in 2005 (Institute for Health and Socio-economic Policy).
- In 2004, the world's 13 largest drug companies reported \$62 billion in profits; the top 12 drug company executives collected \$192.7 million in compensation (IHSP).
- Diagnostic imaging technology has grown to nearly a \$100 billion a year business (IHSP).

Excerpted from *"Seeking Justice in Health Care: Getting from Here to There"*, April 2004 Universal Health Care Action Network (UHCAN). Full report available at: [www.uhcan.org](http://www.uhcan.org)

Some look back at ninety years of failed attempts to achieve universal health care and say, "It can't happen here." Others, looking from the present to a future of ever-higher numbers of uninsured people, rapidly rising health care costs, and limited resources to pay for care, are convinced that it must. After all, every other industrialized democracy made the commitment to health care for all before or during the twentieth century.

However, some of the challenges facing American reformers are unique in their complexity. Obstacles include reconciling the dual costs of health care reform, addressing high costs and waste, working around or against the fragmentation of American health care and the privileged role of special interests, and understanding fundamental moral and ideological disagreements.

#### Dual Goals of Health Reform

The two most basic goals of health care reform are expanding access and controlling costs. At first glance, these goals seem contradictory: if more people have better access to more services, the overall cost of health care will go up. But this is an oversimplification.

#### High Costs and Waste

High costs and waste impede reform by making it seem like expanding access, the chief goal of many justice-oriented reformers, is prohibitively expensive. Based on the misconception that overall costs can be controlled only by reducing use of health care services, this illusion has long hampered reform efforts.

High costs are caused by more than merely high utilization. Causes of high costs include:

- High prices for goods and services, demonstrated most vividly in drug prices;
- High administrative costs due to the enormous complexity of American health care financing (fragmentation): huge numbers of insurance companies and insurance products, frequent gaps in coverage and changes in plans;
- Economic incentives and cultural expectations that promote clinical practices that excessively utilize high cost treatments and inadequately reward promising approaches to care, disease management, and information sharing.

### Overall Fragmentation of Health Care Delivery and Finance

Unlike health care systems in other western democracies – all of which more or less guarantee comprehensive health care to all residents – American health care lacks clear lines of authority and responsibility. It is less a “system” than an assortment of haphazard arrangements, with thousands of small players vying for a good spot in the game.

This contributes to the high cost of American health care by making administration, communication and coordination more difficult and more expensive. Policy solutions also have to be especially creative and inclusive. Health care in the United States is so complex that quick fixes and single-approach solutions are likely to be inadequate.

### The Role of Vested Interests

Many key players in the health care game have a vested interest in seeing the fragmentation that characterizes the status quo continue indefinitely. In health care, because the services clinicians, hospitals, pharmaceutical manufacturers, and others provide are seen as so essential, the balance of power is widely skewed in their favor.

This has direct consequences for the politics of policy change. Many of those who view the status quo as essentially in their best interest are able to spend a lot of money defending those interests. While the activities of lobbyists and campaign donors may not always determine how politicians vote, they certainly influence what politicians vote about, which legislation is even brought to the table, and how it is framed.

### Ideological and Moral Disagreements

Basic moral and ideological percepts underlie many people’s understanding of what sort of health care reform, if any, is desirable. Dialogue often falters where these perspectives diverge.

The *ideological debate* centers on the roles of government and of private enterprise in filling basic human needs. Those who see healthcare as a public good tend to believe that private enterprise can’t be trusted to serve the public interest. Those who believe that health care is a consumer good tend to believe that governments can’t be trusted to spend money wisely or efficiently, and that the market place responds better to changing technologies and trends.

The *moral debate* centers on the degree to which we are responsible for our neighbors. Those who believe that we share common responsibility for everyone’s welfare are more likely to view health care as a right and to believe that the government should have a role in guaranteeing that right. Those who believe that we are at most responsible for ourselves and our families tend to think that adults who want health insurance should find jobs that offer health benefits or purchase private insurance.

### Questions and Activities for Reflection and Research:

1. Recent efforts in the California legislature have included a bill sponsored by Senator Sheila Kuehl. Proponents of this bill say that the single most expensive element in our system is the handling of claims by insurance companies – nearly 30 cents of every health care dollar. Read information contained in “The Health Care for All Californians Act” at [www.onecarenow.org](http://www.onecarenow.org). You may find the Questions and Answers section particularly helpful.
2. As we examine our values regarding health and health care, some questions we might consider are “What is our personal responsibility for our own health?” and “Does the excessive use of high cost treatment for some limit access to basic care for others?” For some reflections on these questions use the [www.calchurches.org/health](http://www.calchurches.org/health) website and go to the link for denominational resources and click on “Evangelical Lutheran Church in America.” This link will take you to their social statement on health. Scroll down to the section on “A Vision of Health Care and Healing as a Shared Endeavor.” Read and reflect on the section titled “Personal Responsibilities.”
3. In the second session of this study we discussed some basic values related to making decisions about health care policy. Draft a brief statement on why you believe health care is a right or a privilege. Use resources from your denomination’s website and/or print resources to support your position.

*We believe that health and wholeness are central to the well being of society. In the Christian tradition, "health" is much more than mere physical well-being; it is harmony and balance in life, encompassing the physical, emotional, and spiritual dimensions of human existence.*

— California Church IMPACT Legislative Principles

## Session Four – Looking Ahead: Tools for the Journey

### Objectives:

- Develop a personal framework for evaluating emerging legislative proposals for access to health care.
- Create an action plan for your congregation.

### Leader Preparation:

- Read through all session materials.
- Visit the project website at [www.calchurches.org/health](http://www.calchurches.org/health). Download and copy handout on current health care legislation and “Suggestions for Action.”
- Prepare a bulletin board or hang up large sheets of paper for participants to attach the results of their research. Create five areas labeled (1) Dual Goals, (2) High Costs and Waste, (3) Fragmentation, (4) Vested Interests, (5) Ideological Disagreements.
- Check meeting space for adequate seating and set up. Placing chairs in a circle is usually the most effective format for discussions.



### Materials Needed:

- Copies of handout *Some Approaches to Achieving Universal Health Insurance Coverage*
- Copies of handout *Questions to Ask About Any Health Care Proposal*
- Copies of “Suggestions for Action”
- Copies of current health care legislation downloaded from the project website [www.calchurches.org/health](http://www.calchurches.org/health).
- Bulletin board pins or tape to attach the research articles/clippings/reports
- Paper and pens/pencils

## Session Outline

- 10 minutes Gathering, Opening Prayer. Invite participants to post the results of their research on the sheets of paper/bulletin board provided. Allow a few minutes for participants to review materials.
- 10 minutes General discussion of research on challenges. For each category, invite those who posted material in that category to share their experience of research. Why did they choose the article/report? What was new or surprising in the information they found? What questions came up for them as they did the research?
- 15 minutes Distribute Copies of handout **Some Approaches to Expanding Health Insurance Coverage**. Working in groups of 2-3, ask participants to read the handout and then discuss the potential “pros and cons” of each model. Ask one person in each group to take notes and list the “pros and cons” for each approach/model.
- 5 minutes Invite groups to share the results of their conversations about the various models.
- 15 minutes Distribute copies of current health care legislation information downloaded from the project website and copies of handout **Questions to Ask About Any Health Coverage Proposal**. Invite participants to read the handouts and then discuss the legislation as a group.
- Does this piece of legislation fit one the models discussed earlier?
  - Use the Questions to Ask About Any Health Care Proposal handout to review the legislation.
- 10 minutes Review the “Suggestions for Action” handout downloaded from the project website for next steps your congregation could take towards increasing health care access. Reflect on the articles posted on the bulletin board/newsprint. Are there connections between the articles and suggested action steps? Determine one next step your congregation could take to become involved in assuring access to health care for ALL Californians.

### California Council of Churches

#### HANDOUT

#### Some Approaches to Expanding Health Insurance Coverage

Americans are worried about their health insurance coverage. They are concerned about the skyrocketing costs of health insurance, about the growing number of businesses that no longer offer health plans, about cutbacks in services that are covered, and about increases in co-payments that are required.

Indeed, in a 2004 poll conducted by the Kaiser Family Foundation, people reported that they were more worried about health care than about any other problem.

- 47% said they were very worried about costs of health care and health insurance,
- 32% of those with health insurance reported that they were very worried about losing it,
- People said they were more worried about the costs of health care and health insurance than about losing their jobs (21%); about not being able to pay their rent or mortgage (27%); about losing their savings in the stock market (23%); and about being a victim of a terrorist attack (20%).

The current anxiety among Americans about the adequacy and the stability of their health insurance is not new. For decades, Americans have been telling pollsters that they regard disparities in health coverage as a national disgrace.

These concerns have created pressures on state and federal legislators to come up with plans for expanding health coverage. In 1965 Congress established Medicare and Medicaid to cover health care expenses for retirees and the poor. Since the mid-1980s, they have expanded coverage for children from low-income families and for low-income adults, but these programs still do not offer or subsidize coverage for large numbers of the uninsured.

Congress and state legislatures have been unable to produce anything like a universal health coverage program beyond their efforts with Medicare and Medicaid. Legislative gridlock seems to be the rule of the day as powerful interests such as physicians, health insurance companies, attorneys, businesses, and consumer groups find themselves at odds with each other in the consideration of potential solutions.

The following represent a sampling of alternative approaches (or “models”) that currently are being considered by lawmakers<sup>4</sup>. They differ in many ways, e.g., in their costs, in the groups that they cover, in the obligations of government, individuals, and businesses. At this point, there is no consensus whatsoever among lawmakers and/or their constituencies about which of these alternatives should guide America’s effort to find solutions for its long-standing health coverage crisis.

4. In general, we have chosen to describe the models offered in “Health Care Coverage in America”, published by the Alliance for Health Reform, for use during the 2004 Cover the Uninsured Week — a “campaign” in which many religious congregations participated. Descriptions of other models are offered by the Institute of Medicine and by the Lewin Group.

### **A Single Payer Universal Health Care System**

A single payer public health insurance program would replace the current patchwork “mixed provider” system in which employers, the government, and/or individuals pay for health care insurance. It is called single payer because a single government agency would replace the role of insurance companies. It is universal because it would cover all residents from birth to death, regardless of employment, income, social status, or pre-existing conditions.

Everyone would participate in this public health insurance program but remain free to choose his or her own private doctors, hospitals, and other providers. Premiums would be linked to income, not the market rates of private insurance.

The system would be funded and administered by the government. In the United States, Medicare is such a system, and like Medicare a universal plan could permit some private insurance coverage. Plans in Europe are similar with broad coverage in the public plan and private coverage for things such as elective surgery. Some countries such as Britain have fully public plans in which the hospitals and medical personnel work for the government. In Canada only British Columbia has government-paid insurance with no private market for supplemental policies. In all cases, however, universal coverage is genuinely that — health care for every resident.



In the United States achieving single-payer universal health care coverage is already being proposed in California and in Congress.

This option would definitely achieve genuine universal health care coverage, as has been done in Canada and Europe. However, while it is important to study these other national models, we can craft an American version of single payer health care so that it meets the health care needs and preferences of the American people.

### **Pay or Play**

Employers would be required either (1) to provide health insurance for their employees, or (2) to pay a payroll tax that would cover all or most of the costs involved in providing their employees with insurance through a public plan.

The federal government would provide a subsidy for employers of low-wage workers. Medicare would be left to function as it currently does. Some proponents argue that two current public health insurance programs, Medicaid and the State Children’s Health Insurance Program, should be merged, but that they, too, should continue to function.

### **Individual Mandates**

Individuals would be required to have or purchase a basic form of health insurance. Some would continue to receive their insurance through employer plans. Others would continue to participate in public insurance plans (e.g., Medicare, MediCal, veterans’ programs). Others would choose to purchase insurance from private companies in a competitive market.

This approach is very similar to that which currently structures automobile insurance requirements. That is, individuals are required to have at least a minimum level of automobile insurance, but they may choose to exceed these minimum requirements.

### Expansion of Existing Public Programs

Many health policy experts argue that the most realistic, politically viable approach to health insurance reform is simply to expand existing programs such as Medicare, Medicaid, and the State Children's Health Insurance Program. They claim that, with minor alterations and with expanded funding, the current mix of programs can offer coverage for all or most of the uninsured. Funding would come from state, local, and federal taxes (including tax increases on private insurance companies).

### Tax Credits or Health Savings Accounts

Private health insurance can be made somewhat more affordable by allowing individuals and/or employers to deduct the cost of health insurance policies from the amount that they owe in income taxes. The credits can either be a fixed amount of money or some percentage of the premiums charged by insurers. Individuals and families that pay no income tax would receive "refunds" to subsidize premium payments. Health Savings Accounts are money set aside before taxes to cover premiums or other medical expense.

### Short term Solutions: Individual State Programs

The journey towards a national health care system has been long and tedious and the destination is still not in view on the horizon. Many states, and California in particular, have begun to introduce legislation that would create a new system for their residents. Many of these proposals incorporate some of the models listed above. For information on the status of current legislation in California go to [www.calchurches.org/health](http://www.calchurches.org/health).





## California Council of Churches

### HANDOUT

## Questions to Ask About Any Health Coverage Proposal

- 1) Is the proposed system truly universal? Will it cover everyone, regardless of income, employment, social status, or pre-existing conditions?
- 2) Is anyone excluded? Does it include immigrants as a whole, and undocumented immigrants in particular?
- 3) Is it comprehensive? Does it include the following:
  - Doctor visits
  - Hospitalization
  - Access to specialists
  - Mental health treatment
  - Occupational health services
  - Nursing home and long-term care
  - Preventive and rehabilitation services
  - Prescription drugs
  - Dental and vision care
  - Medical supplies and equipment?
- 4) Is there a single standard of care, or will there be inferior care for the poor, and superior care for the wealthy?
- 5) Is it cost-effective? Will it cost the average person more or less than what he or she pays now?
- 6) Is its financing fair, consistent with the social justice principles of our churches?
- 7) Does it address health care primarily as a human right or as a commodity? Does it enhance, restrict, or eliminate the role of private, profit-motivated insurance companies?
- 8) Does it have an effective cost control system?
- 9) Does it provide relief for workers who may be displaced by the elimination of private health insurance companies?
- 10) Is the health care coverage affordable to all people?
- 11) Is it accessible so that all people, without geographic restrictions, ethnicity and language differences, and with cultural differences may get care?
- 12) Is the coverage portable so that if you leave a job or change your life conditions through moving, loss of a spouse, etc., you still have coverage?

**California Council of Churches  
Appendix**

**Answers to Pop Quiz on Health Care Access**

1. About how many Americans have no health coverage whatsoever—not even government-sponsored coverage for the poor?  
 47 million
2. In California, what percentage of the population is uninsured?  
 20%
3. What percent of uninsured people in the United States belong to minority populations (for example, Hispanic, African-American, Asian-Pacific)?  
 25%
4. How less likely are uninsured children to receive medical care for common childhood illnesses (e.g. ear infections) than are children who are insured?  
 70%
5. How many uninsured children in the U.S. have parents who work in a small business?  
 550,000
6. What percent of uninsured Americans are in working families?  
 80+%
7. What percent of insured Americans receive their coverage through their workplace?  
 60%
8. What percent of American employers do not offer health coverage to their employees?  
 One-third
9. What percentage of uninsured workers are employed by firms that do not offer health coverage?  
 Two-thirds
10. During the last decade, the average employee premium contribution to his/her health insurance has increased by what percent?  
 75%
11. About what percentage of bankruptcies in the United States are directly related to unpaid medical bills?  
 50%
12. Emergency rooms play a large role in meeting the medical needs of the uninsured. During the past decade, what percent of emergency rooms in California have closed?  
 15%

## California Council of Churches Appendix

### Denomination Web Sites

African Methodist Episcopal Church.....	www.ame-church.com
American Baptist Churches of the West .....	www.abcw.org
Diocese of the Armenian Church of America .....	www.armenianchurch.org
Christian Church (Disciples of Christ).....	www.disciples.org
Christian Methodist Episcopal Church .....	www.c-m-e.org
Church of the Brethren .....	www.brethren.org
Community of Christ.....	www.cofchrist.org
The Ethiopian Orthodox Church .....	www.eotc.faithweb.com
The Episcopal Church .....	www.ecusa.anglican.org
Evangelical Lutheran Church in America .....	www.elca.org
Greek Orthodox Archdiocese of America .....	www.goarch.org
Independent Catholic Churches International .....	www.independentcatholics.org
Moravian Church in America .....	www.moravian.org
National Baptist Convention .....	www.nationalbaptist.com
Presbyterian Church (U.S.A.) .....	www.pcusa.org
Reformed Church in America .....	www.rca.org
Swedenborgian Church.....	www.swedenborg.org
United Church of Christ .....	www.ucc.org
The United Methodist Church .....	www.umc.org
Universal Fellowship of Metropolitan Community Churches.....	www.mccchurch.org

### California Council of Churches Appendix

#### Internet Resources

##### Advocates for Single Payer Universal Health Care

**Health Care — NOW** — A national movement of hundreds of organizations advocating single payer health care, and H.R. 676 in particular. [www.healthcare-now.org](http://www.healthcare-now.org)

**Physicians for a National Health Plan** — A 15,000 member national doctors group that supports single payer health care. [www.pnhp.org](http://www.pnhp.org)

**One Care NOW** — A California coalition to enact a single payer plan. [www.onecarenow.org](http://www.onecarenow.org)

**California Nurses Association** – [www.guaranteedhealthcare.org](http://www.guaranteedhealthcare.org)

##### Other National Resources

**Alliance for Health Reform** — exists to provide an array of resources and viewpoints, in various formats, to elected officials and their staffs, journalists, policy analysts and advocates. [www.allhealth.org](http://www.allhealth.org)

**Center for Healthcare Reform** — part of the healthcare ministry of the Sisters of St. Joseph of Orange. The center is committed to advocate at the federal, state and regional levels, and to promote initiatives that improve healthcare in communities. [www.stjhs.org](http://www.stjhs.org)

**Cover the Uninsured Week** — project of the Robert Wood Johnson Foundation, dedicated to reversing the disturbing trend of rising health care costs that undermine the ability of individuals, businesses and state governments to purchase health care coverage. [www.covertheuninsured.org](http://www.covertheuninsured.org)

**Divided We Fail (AARP)** — [www.DividedWeFail.org](http://www.DividedWeFail.org)

**Faithful Reform in Health Care** — a national interfaith organization and network of clergy and laity working to develop moral principles that must underpin all national and local health care reforms. It seeks to be the “moral conscience” for all federal and state policy choices. Working with secular policy leaders in health care, Faithful Reform brings values discernment to health care policy discussions. [www.faithfulreform.org](http://www.faithfulreform.org)

**Families USA** — a national nonprofit, non-partisan organization dedicated to the achievement of high- quality, affordable health-care for all Americans. [www.familiesusa.org](http://www.familiesusa.org)

**National Council of Churches (USA) Health Task Force** — supports congregations in their health care ministries, equips member communions to participate fully in the current debates on health care policy at state and federal levels, equips congregations to be responsive to health emergencies such as natural disasters, flu epidemics and terrorist attacks, provide health education to their membership with a multifaceted approach to questions of mental, physical and spiritual health. [www.health-ministries.org](http://www.health-ministries.org)

**National Coalition on Health Care** — nation’s largest and most broadly representative alliance working to improve America’s health care. Brings together large and small businesses, labor, consumer, religious and primary care provider groups, and the largest health and pension funds. [www.nchc.org](http://www.nchc.org)

**The Rand Corporation** — a nonprofit institution that helps improve policy and decision making through research and analysis. [www.rand.org](http://www.rand.org)

**Universal Health Care Action Network** — works for comprehensive health care for all in the U.S. through the activation, strengthening, engagement and coordination of local and state-based multi-constituency Health Care Justice coalitions. [www.uhcan.org](http://www.uhcan.org)

**Kaiser Family Foundation** — non-profit, private operating foundation focusing on the major health care issues facing the nation; an independent source of facts and analysis for policymakers, the media, the health care community, and the general public. [www.kff.org](http://www.kff.org)



## California Council of Churches Appendix Internet Resources

### Other State Resources

**California Budget Project** — Through independent fiscal and policy analysis, public education and collaboration with other organizations, the California Budget Project works to improve public policies affecting the economic and social well-being of low- and middle-income Californians. [www.cbp.org](http://www.cbp.org)

**California Catholic Conference** — the official voice of California's Catholic community in the public policy arena. Resources for parishes on a variety of issues. Includes links to resources from the United States Conference of Catholic Bishops and Catholic Charities of California. [www.cacatholic.org](http://www.cacatholic.org)

**California Council of Churches** — a statewide public policy office representing 52 judicatories in 21 denominations throughout California with more than 5,000 congregations and over 1.5 million members, the Council works on a wide range of justice issues in California. The project website for this study is located at [www.calchurches.org/health](http://www.calchurches.org/health)

**Health Access California** — is a statewide health care consumer advocacy coalition of over 200 organizations working for the goal of quality, affordable, health care for all Californians. [www.health-access.org](http://www.health-access.org)

**Jericho — A Voice for Justice** — JERICHO engages the interfaith community throughout California in shaping state public policy that affects individuals and families living in poverty. Jericho lifts up the connection between religious tradition and justice and mobilizes its nonpartisan membership to act. [www.jerichoforjustice.org](http://www.jerichoforjustice.org)

**Lutheran Office of Public Policy** — a justice advocacy ministry of the Pacifica, Southern California West and Sierra Pacific Synods, and the Division for Church in Society of the Evangelical Lutheran Church in America. [www.lutheranpublicpolicyca.org](http://www.lutheranpublicpolicyca.org)

**QueensCare Health and Faith Partnerships** — the Partnership is a growing public-private coalition of over 50 multiethnic neighborhood organizations. They include churches, church-run and charter schools, and social service agencies. A great model of congregations serving their communities! [www.queenscare.com](http://www.queenscare.com)

**St. Joseph Health Systems** — an Orange County-based health ministry that provides a component on moral discernment around health care policy decisions. St. Joseph has a list serve with health related updates and offers trainings on faithful witness on ethics and values for health care. While a Catholic organization, it offers broad, moral frameworks on key health issues. [www.stjhs.org/view/CFHR/aboutus](http://www.stjhs.org/view/CFHR/aboutus)

**Sacramento Health Care Decisions** — works to insure that community values are incorporated into healthcare policy and practice in the Sacramento region. [www.sachealthdecisions.org](http://www.sachealthdecisions.org)

## California Council of Churches Appendix

### The Bible and Health Care

#### God of Healing

Praise the Lord, O my soul, and forget not all God's benefits — who forgives all your sins, **who heals all your diseases.** Psalm 103:2-3

I have seen their ways, but I will heal them; I will lead them and restore comfort to them, creating praise on the lips of the mourners in Israel. "Peace, peace to those far and near," says the Lord. "**And I will heal them.**" Isaiah 57:18-19

O Lord, my God, I cried to you for help and **you have healed me.** Psalm 30:2

I will search for the lost, and bring back the strays. **I will bind up the injured** and strengthen the weak. Ezekiel 34:16

#### Jesus the Healer

"Go and tell John what you hear and see: **the blind receive their sight, the lame walk, the lepers are cleansed, the deaf hear,** the dead are raised, and the poor have good news brought to them." Matthew 11:4-5

One day as Jesus was teaching, Pharisees and teachers of the law, who had come from every village of Galilee and from Judea and Jerusalem, were sitting there. And the power of the Lord was present for him to **heal the sick.** Luke 5:17

For **he had healed many,** so that those with disease were pushing forward to touch him. Mark 3:10

Jesus stood still and ordered the man to be brought to him; and when he came near, he asked him, "What do you want me to do for you?" He said, "Lord let me see again." Jesus said to him, "**Receive your sight;** your faith has saved you." Luke 18:40-42

#### The Disciples as Healers

He called his twelve disciples to him and gave them authority to drive out evil spirits and to **heal every disease and sickness.** Matthew 10:1

As a result, people brought the sick into the streets and laid them on beds and mats so that at least Peter's shadow might fall on some of them as he passed by. Crowds gathered also from the towns around Jerusalem, bringing their sick and those tormented by evil spirits, and **all of them were healed.** Act 5:15-16



## California Council of Churches Appendix

### Some Principles and Guidelines for Evaluating Health Care Proposals and Legislation

In January of 2004, the Institute of Medicine (IOM) released the last of six reports by its Committee on the Consequences of Uninsurance. “The report is the culmination of a series that offers the most comprehensive examination to date of the consequences of lack of health insurance on individuals, their families, communities and the whole society. The report also demonstrates how the principles can be used to assess policy options. The IOM Committee does not recommend a specific coverage strategy. Rather, it shows how various approaches could extend coverage and achieve certain of the Committee’s principles.”<sup>5</sup>

In **Insuring America’s Health: Principles and Recommendations**, the committee offers a set of guiding principles, based on the evidence reviewed in the Committee’s previous five reports and on new analysis of past and present federal, state, and local efforts to reduce uninsurance, for analyzing the pros and cons of different approaches to providing coverage. The principles for guiding the debate and evaluating various strategies are:

- Health care coverage should be universal.
- Health care coverage should be continuous.
- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

To these principles, we would add:

- Health care coverage should be accessible.
- Health care coverage should be portable.

Although all the principles are necessary, the first is the most basic and important. The principles are intentionally general, which allows them to be applied in more specific operational and political processes.<sup>6</sup>

Full text of the report is available at <http://www.iom.edu/report.asp?id=17632>

5. <http://www.iom.edu>, Press Release, January 2004

6. *ibid.*

Notes







Cut along line and mail in.

## California Council of Churches

### Evaluation Form

1. What was the most important learning/experience you gained from the course?
2. What did you want or expect to learn about but didn't? Why?
3. Rank the study materials as you found them useful, on a scale of 1 to 10, with 1 being not useful and 10 being extremely useful:
  - \_\_\_\_\_ Session Plans
  - \_\_\_\_\_ Class Discussions
  - \_\_\_\_\_ Hand Outs
  - \_\_\_\_\_ Web-based resources
  - \_\_\_\_\_ Homework Assignments
4. What are your follow-up plans for future programs and/or advocacy actions?
5. What else would you like to tell us?

Name of Congregation /Organization\_\_\_\_\_

City\_\_\_\_\_

Dates, days and times study held\_\_\_\_\_

Average number of participants\_\_\_\_\_

**Please fax to (916) 488-7310, or mail to the California Council of Churches, 4044 Pasadena Ave, Sacramento CA 95821 at the end of your study. Thank You!**





## Note



**California Council of Churches 2008**