Health Care Reform: Don't Trust It to the Angels!

TERRIE E. TROXEL

All three Synoptic Gospels describe the temptation of Christ following his forty days of fasting in the desert. In one of the temptations, Satan challenges Jesus to free himself from a high pinnacle, usually thought of as the temple in Jerusalem, by jumping and relying on angels to rescue him from a deadly fall. Jesus rebuffs the devil: "It is said, 'Do not put the Lord your God to the test"' (Luke 4:12).

What could the temptations of Christ possibly have to do with the current debate on how to improve—that is, "reform"—the American health care delivery and health care financing systems?

There is near universal agreement among thoughtful leaders that reform is necessary. Our country is on an unsustainable path of spending larger portions of the nation's productivity and wealth on health care. And while our current system provides high-quality care to the great majority, one out of seven citizens lacks health insurance. That's not to say that the uninsured don't have access to health care; but without health care financing, as a group they tend to avoid preventative care and rely on urgent-care facilities for acute health issues. This ultimately imposes undue costs on the system without compensating revenue from or for the care recipient.

Even those with insurance face the possibility of losing coverage if they become unemployed for extended periods or if they cannot afford individual coverage or if they initially seek coverage with a serious preexisting health condition. Society as a whole expresses an aspiration that all persons should have access to quality, affordable health care. As Christians, we are guided to love our neighbor as ourselves and to care for those unable to care for themselves. So, the question is not whether health care and health care financing should be available to all, but rather how can we best arrange the talents God provides to accomplish our objective.

Those who advocate a single-payer, government-controlled health care financing and delivery system as the best line of attack to comprehensive reform have to deal with some annoying facts that discourage such an approach. The latest trustees' report on the outlook for Social Security and Medicare indicates that outlays will exceed the program's revenues from payroll taxes in 2016. The old age and survivors' benefits fund will be completely depleted by 2037. But, fixing the finances of that part of Social Security is considered a "lay-up" compared to the

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Health Care Reform: Get Everyone In!

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Should we have universal health care? Universal health insurance? Universal access to primary health care? Universal access to the conditions under which people can be healthy? These are all possible variations of what the United States should do about the nearly 50 million people lacking health insurance now; about most insured people covered through employment, but one paycheck away from no insurance; and about the many insured who are unable to find care and use emergency rooms for essentials.

There's also health misinformation. Medicare is a government-sponsored, single-payer system. Most Medicaid money is spent on long-term care for the elderly. People who call the U.S. system "the best in the world" must not know that we spend 40% more per capita (for hospitals, doctors, medications, and supplies) than any other nation, but are not 40% healthier, as measured by length of life, deaths of newborns, or any other standard yardstick. Yes, some people in every nation have bad experiences; there is no miraculously perfect system of assuring that everyone gets the care he or she needs, when it's needed, with no errors and no interpersonal tension—that is, gets the care he or she *needs* not *wants* or has "heard about on television." No other country seems to feel as passionate as Americans about prolonging life under almost any circumstances if the machinery and chemicals are available. We seem to forget that life itself is a terminal condition, though for Christians who really believe what they say, death is not the enemy.

Back to the universal health questions posed at the beginning: I believe that the nature of health and illness are such that pooling funds through insurance to assure that care can be paid for when needed is essential. Including the entire population in coverage will help people get care before illness becomes an emergency room issue, and may help control costs. If everyone has a way to pay for care, then we can address the access to care issue more sensibly. The best possible access to care is convenient in geography and time and is provided by professionals whose central focus is helping each person to have as many quality years of life as are reasonable. Specialists, medications, and hospitalizations may all be needed at some point, but should be added when they contribute to the outcome, not just because they are available. Home health care and supportive services including hospice should be added to the mix when needed. Finally, each of us should consider in ad-

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situation with the disability income and the Medicare trust funds. The former is expected to run out of money by 2020. The trust fund that pays for inpatient hospital and nursing home care, Medicare Part A, is scheduled to go broke in 2017. And those dire cost estimates were made before the present great recession had taken its full bite. The unfunded liability associated with Medicare Part D, the drug entitlement program, is estimated to be $8 trillion. In total, the Peterson Institute estimates that the off-balance-sheet obligations associated with Social Security and Medicare amount to more than $56 trillion, or $483,000 for every household in the United States.

It is difficult to view the federal government's management of the Medicare system, which covers perhaps 20% of the nation's citizens, as a model for expanding government-provided health care financing. The Congressional Budget Office has "scored" one health care reform proposal (House Bill 3200) as adding over an additional $1 trillion to the federal deficit over a ten-year period. Instead of bending the cost curve down, that proposal is seen driving the nation deeper into debt. Any argument that coverage can be extended to the uninsured without new costs simply by curtailing fraud and abuse in the current government-financed system, as claimed by Richard Nixon some thirty years ago and now by President Obama, leads one to question why such savings are not currently being captured. Government has shown no ability to control health care costs. Cost control in the form of government-mandated price controls does not result in efficiency, innovation, and quality outcomes. Bringing 30 to 46 million currently uninsured persons under comprehensive health care coverage with emphasis on screening, diagnostic testing, and wellness certainly implies a significant increase in system costs, extensive rationing, or both.

So, we face the challenge of balancing our conflicting values of fiscal responsibility and our desire for universal health care. Should we take a leap of faith on a reform plan rammed through Congress and hope that somehow the better angels of our human nature will make things work out all right? Or, do we follow the more difficult path of changing tax laws, medical liability laws, or insurance laws and contracts to enable consumer-driven health care with subsidies for those who realistically cannot afford to participate in the system?

We can answer Cain's question about being our brother's keepers (Gen 4:9) with an affirmative response. The letter of James makes this clear (2:8, 16). At the same time, our caring for those in need does not remove from them their own personal responsibility to respect and care for their bodies and minds as "temples of the Holy Spirit" (1 Cor 6:19–20). What seems to be most desirable is a well-balanced system of personal responsibility and compassion for the truly in need, a system that focuses on what is driving costs and how we can affect them for the benefit of all. ⊕

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vance what care and treatment we want when dramatic intervention may not result in a return to an active life. This is not rationing care, it's being rational about care.

Other nations with care systems that are more inclusive of the whole population, cost less, and with populations at least as healthy as ours accomplish their goals in a variety of ways. All face the same challenges we do. New, more costly medications are available; new procedures and technology are tempting to use even when they add nothing to quality of life; an aging population has more chronic conditions that need attention. There are two keys to controlling health care costs: the proportion of the budget needed to administer payment for services, and the degree to which decision makers can profit through their choices of products or services. To take up the latter first, there is clear evidence that if a decision maker owns diagnostic equipment, more diagnostic tests will be ordered, whether or not there is any reason to order them. When the income level of a professional is directly tied not to the number of patients or the health of the patients cared for but to the number of activities performed, more tests, surgeries, or procedures will be done, whether or not they improve or lengthen life. That is why salaried professionals do better for less.

The administrative costs stimulate the debate about a single payer. The extra administrative cost of having thousands of different, competing insurance plans in the United States is reputedly more than enough to pay for coverage of all of the uninsured. If medical offices did not have to employ multiple staff members to track up to one hundred different variations on payment schedule, coverage, and billing, costs would drop. The tenfold difference in administrative costs between Medicare and private coverage demonstrates the potential savings. But many people are frightened by or philosophically opposed to any abrupt move away from employer-based insurance and multiple options. In addition, over 3 million people currently employed in administering insurance plans would have to find work in some other part of the economy. The range of structures around the globe illustrates that almost any option, including but not limited to single-payer, would do a better job of controlling costs than what we have.

To answer those opening questions: we have an obligation as a nation to provide universal access to a way to provide and pay for needed care and also to build a public health system that can limit the need for care, through community-wide action such as safe drinking water and school health services. No preference for or opposition to the simplest, cheapest administration (single-payer) should block universality. Get everyone in, provide the care, and then look at whether we can make it better. ⊕

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