

Health Care Coverage for

All:

Discussion
Guide
for
Churches



Prepared by the Bioethics Committee of the Episcopal Diocese of East Tennessee

Health Care Coverage for All: Discussion Guide for Churches

Session 1: Why health policy is a Christian concern

- Session 1 plan
- Resolution C071 adopted by the 2009 General Convention
- Resolution D048 adopted by the 2009 General Convention
- Past actions of the Episcopal Church USA
- A brief history of religion and healing
- Jesus and healing
- Contributors to health care (*Lesser Feasts & Fasts 2006*)
- Visions & Voices video flyer
- Evaluation Form

Session 2: Personal Encounters with the health care system

- Session 2 plan
- Resolution C071 adopted by the 2009 General Convention
- "Americans at Risk" - Families USA
- Hear the Stories - Cover the Uninsured
- Health Crisis Stories - Families USA
- Evaluation Form

Session 3: What we can/should do

- Session 3 plan
- Resolution C071 adopted by the 2009 General Convention
- Health, Money, and Fear video website
- Sick Around the World - sketch of health system in 5 countries
- Sick Around the World - 4 health care models
- Personal Responsibility for Health
- Evaluation Form

Resources

- Videos, Web Sites, Books & Articles
- Some especially appropriate prayers
- Glossary of health reform terminology

Session 1 Plan

Why health policy is a Christian concern

1. **Open with prayer.** (See listing of especially appropriate prayers in the [Resources](#) section at end of guide.)
2. **Set some guidelines** for the discussion. Here are some suggestions:
 - The only name I may use is my own name.
 - The words "always" and "never" are not allowed.
 - I will listen and not interrupt.
 - I will not blame, shame, or attack.
 - I will try to be patient.
 - I will think in a "both/and" manner, rather than in an "either/or" manner.
3. **Introductions** (5 minutes)
4. **Review** the 2009 General Convention resolution C071 (5 minutes) - Note also Resolution D048 which was also passed by the 2009 General Convention as well as position statements related to health care passed by prior General Conventions.
5. **Review** the historical role of the church in health care (10 minutes)
6. **Share** a few New Testament accounts of healing (10 minutes) - if the group is large, divide into small groups for this and the next parts. Especially appropriate passages are printed in bold.
7. **Share** information about several saints in our church calendar and the roles they have played in health care - (5 minutes) - Choose a saint with special connections to your parish or to the date on which the discussion is being held, or consider the especially appropriate ones printed in bold.
8. **Show** video - statements by religious leaders in the "Vision and Voice" video (18 minutes)
<http://visionandvoice.org>
9. **Discuss** the video, healing accounts, and saints as time permits
10. **Close with Prayer** (See listing of especially appropriate prayers in the [Resources](#) section at end of guide.)

We would love to hear how your session went. Please have participants fill out the [questionnaire](#) attached and mail them (or your tally) to: Glenn C. Graber, 7308 Manderly Way, Knoxville, TN 37909

FINAL VERSION - Concurred

Resolution: C071
Title: Health Care Coverage for All
Topic: Health Care
Committee: 09 - National and International Concerns
House of Initial Action: Deputies
Proposer: Diocese of East Tennessee

Resolved, the House of Bishops concurring, That the 76th General Convention call on its congregations to undertake discussions within the parish of the issue of health care coverage in the United States, including:

- a) recognition that health is multi-dimensional, with spiritual, social, environmental, and mental elements as well as physical,
- b) reminder of personal responsibility for healthy life choices and concern for maintaining one's own health,
- c) proclaiming the Gospel message of concern for others which extends to concern for their physical health as well as spiritual well-being,
- d) responsibility as a parish to attend to the needs (including health-related needs) of others, both other members of the parish family and those of the wider community, the nation, and the world,
- e) recognition that there are limits to what the healthcare system can and should provide and thus that some uncomfortable and difficult choices may have to be made if we are to limit healthcare costs; and be it further

Resolved, That, The Episcopal Church urge its members to contact elected federal, state and territorial officials encouraging them to:

- a) create, with the assistance of experts in related fields, a comprehensive definition of "basic healthcare" to which our nation's citizens have a right,
- b) establish a system to provide basic healthcare to all,
- c) create an oversight mechanism, separate from the immediate political arena, to audit the delivery of that "basic healthcare,"
- d) educate our citizens in the need for limitations on what each person can be expected to receive in the way of medical care under a universal coverage program in order to make the program sustainable financially,
- e) educate our citizens in the role of personal responsibility in promoting good health; and be it further,

Resolved, That this resolution be distributed to all Provinces and dioceses of The Episcopal Church for their consideration and support.

EXPLANATION

We, the members of the Bioethics Commission of the Episcopal Diocese of East Tennessee believe that:

- a) provision of basic healthcare for all is a duty of a nation of Judaic-Christian values and, furthermore,
- b) the current healthcare delivery system of the United States is flawed in failing to provide comprehensive coverage for 47 million of our citizens and, furthermore,
- c) our current system with its escalating costs represents a non-sustainable financial challenge to employers competing in a global market,
- d) the steps we specify above are all necessary to address this problem adequately.

* FINAL VERSION - Concurred

Resolution: D048
Title: Adoption of a "Single Payer" Universal Health Care Program
Topic: Health Care
Committee: 09 - National and International Concerns
House of Initial Action: Deputies
Proposer: The Rev. Gary Commins

Resolved, the House of Bishops concurring, That the 76th Convention of the Episcopal Church urge passage of federal legislation establishing a "single payer" universal health care program which would provide health care coverage for all of the people of the United States; and be it further

Resolved, That the General Convention direct the Office of Government Relations to assess, negotiate, and deliberate the range of proposed federal health care policy options in the effort to reach the goal of universal health care coverage, and to pursue short-term, incremental, innovative, and creative approaches to universal health care until a "single payer" universal health care program is established; and be it further

Resolved, That the Episcopal Church shall work with other people of good will to finally and concretely realize the goal of universal health care coverage; and be it further

Resolved, That church members and the Office of Government Relations communicate the position of the Episcopal Church on this issue to the President and Members of Congress, and advocate passage of legislation consistent with this resolution.

EXPLANATION

The Episcopal Church, along with several other denominations in the National Council of Churches, previously called upon the Congress and the President to ensure universal access to health care for all people in the United States by the end of 2006.

That deadline has now passed, and the situation is worse than ever. More than 47 million people in the U. S. are currently without health insurance, more than 75 million went without for some length of time within the last two years, and millions more have inadequate coverage or are at risk of losing coverage. People of color, immigrants and women are denied care at disproportionate rates, while the elderly and many others must choose between necessities and life sustaining drugs and care. Unorganized workers have either no or inadequate coverage. The Institute of Medicine has found that each year more than 18,000 in the U. S. die because they had no health insurance.

While we in the United States spend more than twice as much of our gross domestic product as other developed nations on health care (\$7,129 per capita), we remain the only industrialized country without universal coverage, and the United States performs poorly in comparison on major health indicators such as life expectancy, infant mortality and immunization rates.

Almost one-third (31 percent) of the money spent on health care in the United States goes to administrative costs. Single-payer financing is the best way to recapture this wasted money. The potential savings on paperwork, more than \$350 billion per year, are enough to provide comprehensive coverage to everyone

without paying any more than we already do.

Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, long-term care, mental health, dental, vision, prescription drug and medical supply costs. Patients would regain free choice of doctor and hospital, and doctors would regain autonomy over patient care.

Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO / group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards.

A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing.

** Note: The final language, as well as the final status of each resolution, is being reviewed by the General Convention office. The Journal of the 76th General Convention and the Constitution and Canons will be published once the review process has been completed.*

Resolution Number: 1991-A099

Title: Call for a System of Universal Access to Health Care

Legislative Action

Taken: Concurred As Submitted

Final Text:

Resolved, the House of Deputies concurring, That the 70th General Convention decries the inequitable health care delivery system of the United States of America and calls upon the President, the Congress, Governors and other leaders to devise a system of universal access for the people of our country.

Resolution Number: 1994-A057

Title: Adopt Church Principles on Access to Health Care

Legislative Action

Taken: Concurred As Amended

Final Text:

Resolved,

the House of Bishops concurring, That this 71st General Convention of the Episcopal Church adopt the following four principles as the position of the Episcopal Church regarding health care:

- That universal access to quality, cost effective, health care services be considered necessary for everyone in the population.
- That "quality health care" be defined so as to include programs in preventive medicine, where wellness is the first priority.
- That "quality health care" include interdisciplinary and interprofessional components to insure the care of the whole person--physiological, spiritual, psychological, social.
- That "quality health care" include the balanced distribution of resources so that no region of the country is underserved.

Resolution Number: 1997-A059

Title: Authorize a Theological Guide on the Church's Response to Health Care

Legislative Action

Taken: Concurred as Amended

Final Text:

Resolved,

That the 72nd General Convention of the Episcopal Church authorize the Standing Commission on Health, or other agency of the Executive Council, to produce a theological introduction and study guide on the changing role of the church in the new health care environment, prepared for congregations and those with questions and concerns in this area; and to seek the services of a consultant/educator for this project.

Resolution Number: 2000-A079

Title: Create an Association of Episcopal Health Care Groups and Individuals

Legislative Action

Taken: Concurred as Substituted

Final Text:

Resolved,

That the Executive Council direct the Office of the Bishop for the Armed Services, Healthcare and Prison Ministries to convene representatives of the Episcopal healthcare groups (including the Association of Episcopal Healthcare Chaplains and the National Episcopal Healthcare Ministries) and individuals representing various professions in healthcare and in healthcare policy (recognizing the need for advice on the financial challenges inherent in this area), as well as those engaged in the teaching of, and research on medical ethics and end-of-life issues; and be it further

Resolved,

That this Office and group work in cooperation with the Office of Government Relations, as well as appropriate interfaith and ecumenical organizations to articulate and communicate to public policy makers and the public, the positions of the Episcopal Church with regard to healthcare policy. This will include: advocacy for a healthcare system in which all may be guaranteed decent and appropriate primary healthcare during their lives and as they approach death; keeping abreast of the rapidly changing healthcare market and developments in biomedical research as they affect health-related public policies; collecting, collating, and developing resources and teaching materials related to access to healthcare for the use of dioceses, congregations, and individuals; and be it further

Resolved,

That this Office develop structures which will further useful cooperation and support among the institutions, organizations, and individuals engaged in healthcare; and be it further

Resolved,

That the Office of the Bishop for Armed Services, Healthcare and Prison Ministries report to the 74th General Convention the results of this action.

Resolution Number: 2003-A124

Title: Reestablish a Standing Commission on Health

Legislative Action

Taken: Concurred as Substituted (*but not funded*)

Final Text:

Resolved,

That the 74th General Convention reaffirm the commitment of The Episcopal Church in providing a Christian response to the health care needs of those within our nation, as expressed in the 1991 and 1994 Blue Book reports of the Standing Commission on Health and the 2000 Blue Book Report of the Standing Commission on National Concerns; and be it further

Resolved,

That the 74th General Convention reestablish a Standing Commission on Health and that it direct Executive Council to appoint a person to the staff at The Episcopal Church Center with background in and knowledge about health care policy to assist this commission, and that their joint duties include:

1. Articulating and communicating positions adopted by The Episcopal Church on health care policy to Episcopalians, the public, and public policy makers;
2. Advocating, in cooperation with the Office of Government Relations, for a health care system in which all may be guaranteed decent and appropriate primary health care during their lives and as they approach death;
3. Bringing together those within The Episcopal Church who develop, provide, and/or teach health care and health care policy to continue to develop a Christian approach to pressing issues that affect the health care system of this nation;
4. Understanding and keeping abreast of the rapidly changing health care market and developments in biomedical research that affect health policy;
5. Collecting and developing resources and teaching materials related to access to health care for the use of dioceses, congregations, and individuals;
6. Advocating health ministry in and through local Episcopal congregations; and be it further

Resolved,

That the 74th General Convention direct the Executive Council to report to the 75th General Convention about this appointment; and be it further

Resolved,

That the General Convention request the Joint Standing Committee on Program, Budget and Finance to consider a budget allocation of \$200,000 for implementation of this resolution;

A BRIEF HISTORY OF RELIGION AND HEALING

(A summary of *The Church and Healing*, by Carl J. Scherzer)

Healing and religion were conceived as identical by the ancient Greeks and Romans. Their temples were used as places where sacrifices could be brought to assuage the anger of god or gain his favor so that health might be restored. The Greeks excelled in the healing arts in the Western civilization. The physician was a thinker as well as a healer. Hippocrates developed the method of examining a sick person to determine the cause of illness.

At about the time Jesus was born there was already a "hospital" on an island in the Tiber River near Rome. It was used as a place to expose ill and overworked slaves. If the slave recovered, he did not have to return to his master. The island was soon used by many poor people. However, other hospitals were built, primarily for the use of Roman soldiers. Luke, one of the early converts to Christianity, is called physician in the Scripture (Col. 4:14). His name indicates his Greek origin. Along with other early followers of Jesus he manifested a great interest in sick people. In the Acts of the Apostles, he tells about the miracles that were wrought by the Holy spirit and by the apostles and other disciples. As a physician he was also especially interested in our Lord's miracles of healing.

Jesus was very much concerned about the health of people. We know that to be true because he performed more miracles of healing than of any other category. While Jesus accepted the scientific knowledge available in his time, he did not stop there. He recognized the importance of psychological and spiritual factors in sickness and health. Jesus' spirit of compassion influenced the Christian's attitude toward people who were poor, or oppressed, or underprivileged; and also caused them to be concerned about the sick.

The diaconate in the very early church had its origin in the ministry of help. It was not long until there were deaconesses also, the first one mentioned being Phebe. As the Church grew in numbers the orders of "helpers" made an ever greater contribution in the ministry to the sick.

The man who may have influenced the early Church in its relation to healing more than any other was the Roman writer Pliny, who lived at the time of the apostles. His works were acceptable to the Christians even though he was not a Christian himself. He believed that for every disease there as a plant to cure it. The Christians believed that everything on earth has a value or a purpose, so they accepted Pliny's philosophy and his works were in great favor among them. Later monks cultivated various plants and herbs for their medicinal values.

Much of Jesus' healing and that of his disciples was in the form of casting out demons or unclean spirits. Jesus also taught his disciples to use oil. Mark wrote, "And anointed with oil many that were sick, and healed them." Also used for healing was prayer and later Holy communion and relics.

Deaconesses, widows, and virgins were three orders that grew out of the early church. The nursing profession traces its origins to these early Christian orders. It was one of the deaconesses, Fabiola, who founded the first charity hospital in Rome about 300 A.D. Probably the

best known of all the deaconesses was Paula, who was a friend of Fabiola. Paula founded a hospital at Bethlehem.

The Church reached into the field of nursing through bishops and monks also. St. Basil, a Greek bishop of Caesarea, is credited with setting up a system of visiting the sick and a system of nursing care. There was not much glamour to caring for or healing the ordinary or the poor sick, and it was in this medical field among the poor that the Church made its most significant contribution in the post apostolic period. Healing was for all people, not only for certain groups or classes of society!

Moving into the medieval age, the Church was the primary medium through which the healing arts were promoted. As mentioned, roots and herbs were cultivated by the monks, and members of the orders read what literature was available on healing and studied Galen's works on anatomy. They even performed surgery to some extent. But surgery was inadvertently stopped by an edict of Pope Boniface VIII, who decreed that a human body could not be cut up (which had become a way of returning the remains of crusaders back to Europe from the Holy Land). While the edict was not intended to forbid dissection of a human body for medical study, that was one of the results and surgery fell into disrespect.

In this period, almost every monastery had rooms for the sick, and hospitals were built in connection with cathedrals. As the orders of Deaconesses, Widows, and Virgins declined, male nursing orders were founded, such as the Knights Hospitalers and the Teutonic Knights. It was through the crusades that leprosy was brought back to Europe. Hospitals, or lazarettos, were built by the monks to care for the lepers. At one time there were two thousand lazarettos in France and two hundred in England.

New opportunities for women to serve the sick arose through orders that arose, such as the Benedictines, founded by Benedict of Nursia in 529, and the Beguines, founded by Lambert of the Netherlands. Also from this time came the Sisters of Mercy, Sisters of Charity, and Little Sisters of the Poor.

During the medieval times the sacrament of confession and penance became associated with healing. Private confession began to replace public confession. The church decreed at the Council of Liege in 710 that everyone should make confession to the parish priest at least once every year. After that decree, in most hospitals and shrines a patient who came or was brought for cure made confession first.

As the Reformation approached, the belief in witchcraft was held by almost everyone and it was believed that many illnesses were caused by witchcraft. Martin Luther, a leader in the Reformation, did not believe in the worship of saints, or the use of relics or shrines for the purpose of healing. He was interested in the sick and in healing, using prayer and Scripture instead. He accepted the scientific medical knowledge of his day, but also believed in demon possession. He felt the visits of the spiritual advisor were just as important as those of the doctor. Thus, the role of the pastor in healing grew in the period.

As part of the Counter Reformation, new religious orders grew up in the Roman Church that promoted ministry to the sick, such as the Society of the Jesuits, founded by Ignatius of Loyola. Francis Xavier became a founder and pioneer in medical missions. St. Vincent, who formed the

order of the Sisters of Mercy and other orders for healing, instructed that one should care for the sick regardless of how loathsome the disease might be, and to never fear death or leave the impression that death is to be feared. In this same time, the anointing with oil for healing declined and was replaced by extreme unction. After the Council of Trent in 1551, the sacrament of extreme unction became even more regarded as a means of preparing the patient for death.

In England, the king became associated with healing. The sick were brought to the king, kneeled before him, were touched as the king's chaplain intoned, "He put his hands upon them, and he healed them." Queen Anne was the last to practice the touch. Later we see faith healing coming into play by such figures as George Fox of the Quakers.

While the office of the pastor grew in the time of the Reformation, the gradual lack of interest in nursing care caused many hospitals to close. This became known as the "dark period" in nursing history. In the midst of this problem, there were efforts among the Protestant Churches to revive nursing orders. John Wesley's interest in healing led to the founding of dispensaries, orphanages, stranger's societies, refuges for widows, hospitals, and other philanthropic institutions.

Without much luck in the eighteenth century, there was some success in the nineteenth century to revive the diaconate. Some young Christian women who wanted to be nurses, but did not like the strictness of the church diaconate, helped establish independent orders, such as the Sister of the Red Cross.

The diaconate spread to England and the United States. With these orders came interest by various churches to establish hospitals, including the Lutherans, Methodists, Episcopalians, Mennonites, Presbyterians, and Baptists. Nearly all major Protestant denominations, as well as the Catholic Church, have Church-related hospitals. These were founded on the religious principles of Jesus - caring for the poor and sick and any who need medical and spiritual attention.

Healing in Jesus' Ministry

Jesus clearly is concerned with healing and health, as we see in the gospels. In truth, a large part of the synoptic gospels is reflective of his concern for health, particularly among the poor and marginalized.

- The healing of Peter's mother-in-law (Mk 1:29-31)
- The sick healed at evening (Mk 1:32-34)
- The healing of a leper (Mk 1:40-45)
- **The healing of the paralytic (Mk 2:1-12)**
- The healing of the man with the withered hand (Mk 3:1-6)
- **Jesus heals the multitudes (Mk 3:7-12)**
- The Gerasene demoniac (Mk 5:1-20)
- Healings at Gennesaret (Mk 6:53-56)
- **The healing of the deaf person with a speech impediment (Mk 7:31-37)**
- The healing of the boy with a spirit (Mk 9:14-29)
- **The healing of Bartimaeus (Mk 10:46-52)**
- The centurion's servant (Matt 8:5-13)
- **Jairus' daughter (Matt 9:18-26)**
- Healing of a woman with hemorrhaging (Matt 9:20-22)
- The healing of a demoniac who was mute (Matt 9:32-34)
- The healing of many sick people (Matt 15:29-31)
- **Two blind men healed (Matt 9:27-31)**
- The healing of the crippled woman (Lk 13:10-17)
- **The healing of a man with dropsy (Lk 14:1-6)**
- The healing of the ten lepers (Lk 17:11-19)
- **Healing of man at Bethzatha (Jn 5:2-13)**

Contributors to Health Care - Lesser Feasts and Fasts 2006

Brigid - February 1

Catherine of Siena - April 29

Ephrem of Edessa - June 10

Basil the Great - June 14

Laurence - August 10

Florence Nightingale - August 12

Constance and her Companions - September 9

Hildegard - September 17

St. Francis of Assisi - October 4

St. Luke the Evangelist - October 18

St. Jude - October 28

Margaret, Queen of Scotland - November 16

Elizabeth, Princess of Hungary - November 19

Kamehameha & Emma, King and Queen of Hawaii - November 28

Vision and Voice

<http://visionandvoice.org>

“Faithful Citizens and Health Care: Join other communities of faith in bringing an important perspective to the transformation of U.S health care.

As people of faith, we know that health care is essential for each of God’s children. Together, we can create a shared vision and strong voice for a health care future that respects the dignity of each person and the well-being of all. Invite your faith community to join this important interfaith effort. You’ll find the things you need to get started on this Vision and Voice web site.”

Post-Event Evaluation

Please complete this document prior to your departure. We will use it to see how well we did on this event, and how we may plan for further events. Your participation is appreciated!

PRIOR TO THIS SESSION:

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I already had an adequate understanding of issues about health care coverage and the church's role in ensuring health care coverage for all | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I had already: | | Yes | | No |
| a. participated in at least one discussion of these issues within my parish. | | <input type="checkbox"/> | | <input type="checkbox"/> |
| b. seen my parish develop plans to address health care needs within the parish | | <input type="checkbox"/> | | <input type="checkbox"/> |
| c. seen my parish develop plans to address health care needs within our community | | <input type="checkbox"/> | | <input type="checkbox"/> |
| d. developed plans (personally or through the parish) to address the issue of health care coverage for all at the national level | | <input type="checkbox"/> | | <input type="checkbox"/> |

AFTER THIS SESSION:

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I have a much better sense of the issues involved in health care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have a much better sense of how members of my parish may address health care needs within the parish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have a much better sense of how members of my parish may address health care needs within my community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I have a much better sense of how I and/or members of my parish may address health care coverage for all at the national level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I believe this is something that should be pursued further at the parish and/or the diocesan level. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please use space below and on the back of this sheet to provide us with comments you would feel helpful, such as telling us of particular successes or good things about this session, or ideas we could use to improve future sessions.

Thank you for attending and participating!

Session 2 Plan

Personal encounters with the health care system

1. **Open with prayer** (See listing of especially appropriate prayers in the [Resources](#) section below.)
2. **Set some guidelines** for the discussion. Here are some suggestions:
 - The only name I may use is my own name.
 - The words "always" and "never" are not allowed.
 - I will listen and not interrupt.
 - I will not blame, shame, or attack.
 - I will try to be patient.
 - I will think in a "both/and" manner, rather than in an "either/or" manner.
3. **Review** key points from Session #1: the historical role of Christian churches in healthcare, the example of Christ in the New Testament healing accounts and of saints of the church with connections to healthcare, other grounds for recognizing the mission of the church and church members in considering the health of others. (5 minutes)
4. **Read** the General Convention Resolution on Health Care Coverage For All (if the group has already read this during the first session, at least take a few moments to remind the group of its key provisions. See especially the "Explanation" section of the resolution.)
5. **Read** the following statistics that demonstrate the problems with our current health care delivery system (*or duplicate and distribute "Americans at Risk" attachment*) (5 minutes)
 - a) One in three people under 65 were uninsured during some part of the years 2007 and 2008
 - b) One fourth of those uninsured were uninsured for all 24 months and 75% were uninsured for at least 9 of those 24 months
 - c) 80% of the uninsured were in working families, only 16% were not in the labor force
 - d) 60% of the uninsured were families in the poverty level and another 52% were in the 100-200% of the poverty level
 - e) 55% of Hispanics, 40% of African-Americans and 34% of other minorities were without insurance compared to 26% of Caucasians had no health insurance in 2007-2008
6. **Play** recordings from the http://covertheuninsured.org/the_issue/hear_the_stories website (10 minutes) - depending on the audio-visual capabilities at your site you can play audio segments and/or video segments from the site. Especially recommended segments: Joe Cesa, Cris Kosiel, Nancy Gerber, Martha Doster.
7. **Invite** selected attendees to describe a personal encounter with our health care/insurance system (15 minutes)
 - it would be good to line these up in advance, selecting a mixture of perspectives (e.g., health professionals, administrators as well as patients) and including positive as well as negative experiences
 - you might break into small groups for this if the group is large
 - explain at the start that, in order to give everyone who is to share a story a fair chance, each

account will be limited to 1 minute - appoint a timekeeper for each small group)

8. **Consider together** what an ideal, Christian focused healthcare system would look like and discuss how that ideal system compares with the current system and other options being discussed in Congress at this time. (15 minutes)
 - Hand out a piece of paper to each person - have them list 5 features that would make the healthcare system more in line with Christian values - then compare the lists (take up the lists at the end to use in Session #3 to compare with provisions of health care plans being discussed on the national scene)
9. **Urge participants** to follow the national discussion on health care reform during the next week in preparation for Session 3.
10. **Close with Prayer** (See listing of especially appropriate prayers in the [Resources](#) section below.)

We would love to hear how your session went. Please have participants fill out the [questionnaire](#) attached and mail them (or your tally) to: Glenn C. Graber, 7308 Manderly Way, Knoxville, TN 37909

FINAL VERSION - Concurred

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House of Initial Action: Deputies
Proposer: Diocese of East Tennessee

Resolved, the House of Bishops concurring, That the 76th General Convention call on its congregations to undertake discussions within the parish of the issue of health care coverage in the United States, including:

- a) recognition that health is multi-dimensional, with spiritual, social, environmental, and mental elements as well as physical,
- b) reminder of personal responsibility for healthy life choices and concern for maintaining one's own health,
- c) proclaiming the Gospel message of concern for others which extends to concern for their physical health as well as spiritual well-being,
- d) responsibility as a parish to attend to the needs (including health-related needs) of others, both other members of the parish family and those of the wider community, the nation, and the world,
- e) recognition that there are limits to what the healthcare system can and should provide and thus that some uncomfortable and difficult choices may have to be made if we are to limit healthcare costs; and be it further

Resolved, That, The Episcopal Church urge its members to contact elected federal, state and territorial officials encouraging them to:

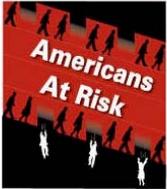
- a) create, with the assistance of experts in related fields, a comprehensive definition of "basic healthcare" to which our nation's citizens have a right,
- b) establish a system to provide basic healthcare to all,
- c) create an oversight mechanism, separate from the immediate political arena, to audit the delivery of that "basic healthcare,"
- d) educate our citizens in the need for limitations on what each person can be expected to receive in the way of medical care under a universal coverage program in order to make the program sustainable financially,
- e) educate our citizens in the role of personal responsibility in promoting good health; and be it further,

Resolved, That this resolution be distributed to all Provinces and dioceses of The Episcopal Church for their consideration and support.

EXPLANATION

We, the members of the Bioethics Commission of the Episcopal Diocese of East Tennessee believe that:

- a) provision of basic healthcare for all is a duty of a nation of Judaic-Christian values and, furthermore,
- b) the current healthcare delivery system of the United States is flawed in failing to provide comprehensive coverage for 47 million of our citizens and, furthermore,
- c) our current system with its escalating costs represents a non-sustainable financial challenge to employers competing in a global market,
- d) the steps we specify above are all necessary to address this problem adequately.



A Report from Families USA, March 2009

Americans at Risk: One in Three Uninsured

KEY FINDINGS

One in Three Uninsured: 2007-2008

- 86.7 million people under the age of 65 went without health insurance for some or all of the two-year period from 2007 to 2008.
- One out of three people (33.1 percent) under the age of 65 were uninsured for some or all of 2007-2008.

Number of Months Uninsured

- Of the 86.7 million uninsured individuals, three in five (60.2 percent) were uninsured for nine months or more. Nearly three-quarters (74.5 percent) were uninsured for six months or more.
- Among all people under the age of 65 who were uninsured in 2007-2008, one quarter (25.3 percent) were uninsured for the full 24 months during 2007-2008; 19.5 percent were uninsured for 13 to 23 months; 15.4 percent were uninsured for nine to 12 months; 14.3 percent were uninsured for six to eight months; and 20.1 percent were uninsured for three to five months. Only 5.4 percent were uninsured for two months or less.

Work Status of the Uninsured

- Four out of five individuals (79.2 percent) who went without health insurance during 2007-2008 were from working families: 69.7 percent were in families with a worker who was employed full-time, and 9.5 percent were in families with a worker who was employed part-time.
- In addition, 4.6 percent were looking for work.
- Of the people who were uninsured during 2007-2008, only 16.2 percent were not in the labor force—because they were either disabled, chronically ill, family caregivers, or not looking for employment for other reasons.

Income Level of the Uninsured

- Three out of five individuals (58.7 percent) in families with incomes below the federal poverty level (\$21,200 a year for a family of four in 2008) went without health insurance in 2007-2008.
- More than half (52.0 percent) of individuals in families with incomes between 100 and 199 percent of poverty (between \$21,200 and \$42,400 a year for a family of four in 2008) went without health insurance in 2007-2008.
- The likelihood of being uninsured decreases considerably with increased income, but nearly one in five (17.9 percent) people in families with incomes at four times the poverty level or above went without health insurance in 2007-2008.

Every Racial and Ethnic Group Is Affected

- Hispanics/Latinos, African Americans, and people of other racial or ethnic minorities were much more likely to be uninsured than whites: 55.1 percent of Hispanics/Latinos, 40.3 percent of African Americans, and 34.0 percent of other racial and ethnic minorities went without health insurance in 2007-2008, compared to 25.8 percent of whites.
- Although racial and ethnic minorities are more likely to be uninsured, whites accounted for nearly half (49.8 percent) of the uninsured in 2007-2008.

Every Age Group Is Affected

- Of the total 86.7 million uninsured people in 2007-2008, 60.1 million were uninsured adults (between 19 and 64 years of age).
- The likelihood of being uninsured declined among adults as they grew older. The percentage who were uninsured was highest among 19- to 24-year-olds (49.5 percent) and 25- to 44-year-olds (36.3 percent). The percentage who were uninsured declined for 45- to 54-year-olds and 55-to-64-year-olds, to 25.5 percent and 21.2 percent, respectively.

Source: <http://www.familiesusa.org/resources/publications/reports/americans-at-risk-findings.html>



Published on *Cover the Uninsured* (<http://covertheuninsured.org>)

[Home](#) > [The Issue](#) > Hear the Stories

Hear the Stories



Mark Jacobs ^[1]

McMinnville, Tennessee

^[1] Mark and his family own a small lumber company that has operated in the community since 1873. When the family acquired the company, they kept the previous benefits and continued to pay two-thirds of all employee and family medical coverage costs. Mark worked alongside his employees for years and makes sure they have the health care coverage they need to stay healthy.



Nancy Gerber ^[2]

Spokane, Washington

^[2] Three years ago, Nancy was diagnosed and treated for stage-four uterine cancer. At the time, Nancy was covered under Washington State's Basic Health plan. Although she had coverage at the time of her surgery and chemotherapy, she has since lost coverage and is unable to pay for valuable follow-up care.



Chris Koziel ^[3]

Chicago, Illinois

^[3] Chris thought his medical troubles were over after successfully completing the chemotherapy and radiation for his leukemia - but after losing his health care coverage, he has been forced to make countless decisions against getting the tests, surgeries and basic medical care he knows he needs because he cannot afford them.



Martha Doster ^[4]

Albuquerque, New Mexico

^[4]

Martha is an all-too typical example of a small business owner who finds herself unable to afford health care coverage for her small staff and continues to struggle with the high premiums of her own health care coverage.



Sarita Scarbrough ^[5]

Houston, Texas

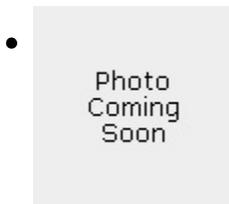
^[5] Sarita lost her health coverage when she left her county and city government job to start her own printing business. At the height of her business, Sarita had 10 employees but could not afford to provide health coverage for them. She has since had to change her business model and now contracts only with independent contractors for the printing work she does.



Catherine Edwards ^[6]

Carthage, Illinois

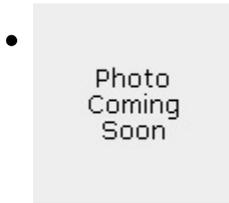
^[6] Catherine Edwards, 54, Carthage, Illinois, is a divorced mother of two children, Renee, 21, and Douglas, 15. Until April of last year she worked as a machine operator for an automobile parts manufacturer.



Becky and Jimmy Picchetti ^[7]

Chicago, Illinois

^[7] When Becky and Jimmy's son Tommy was only two weeks old, his doctors diagnosed him with heart disease. This was only the beginning of several serious health problems to strike Tommy in his first two months. His heart surgery led to other complications, including a stroke and bowel infection, so he had to be monitored in the hospital for six additional weeks. Afterwards, Becky and Jimmy took Tommy home where he was able to recover and play with his older brother, Andy.



Jessica Thompson ^[8]

Atlanta, Georgia

^[8] Jessica is a part-time daycare worker with three children on PeachCare, the Children's Health Insurance Program (CHIP) in Georgia. All three of her children—five-year-old Timothy, two-year-old Reanne and stepdaughter, Lexi—receive excellent care through the program.



Sarah McMasters ^[9]

Sagamore Hills, Ohio

"Health care is an essential need for anyone to survive. As the costs to receive it are rising, less and less people are now covered in case of a medical emergency."



• **Jonathan Hale** ^[10]

Windham, New Hampshire

"Sometimes you don't know what you have till it's gone. Both of my parents are hard working and loving parents. My dad always had a stable job and my mom was a substitute teacher while my two brothers and I were growing up. My father's employer provided excellent health insurance for our family. One day that all changed."

Source URL: <http://covertheuninsured.org/stories>

Links:

- [1] <http://covertheuninsured.org/content/mark-jacobs>
- [2] <http://covertheuninsured.org/content/nancy-gerber>
- [3] <http://covertheuninsured.org/content/chris-koziel>
- [4] <http://covertheuninsured.org/content/martha-doster>
- [5] <http://covertheuninsured.org/content/sarita-scarbrough>
- [6] <http://covertheuninsured.org/content/catherine-edwards>
- [7] <http://covertheuninsured.org/content/becky-and-jimmy-picchetti>
- [8] <http://covertheuninsured.org/content/jessica-thompson>
- [9] <http://covertheuninsured.org/content/sarah-mcmasters>
- [10] <http://covertheuninsured.org/content/jonathan-hale>
- [11] <http://covertheuninsured.org/stories?page=1>
- [12] <http://covertheuninsured.org/stories?page=2>



Health Care Crises - from Families USA

Uninsured Face Avalanche of Health Costs (May 28, 2009)

<http://www.reuters.com/article/healthNews/idUSTRE54Q63B20090528>

Health Care Eating into N.J. Incomes (May 12, 2009)

http://www.northjersey.com/health/insurance/Health_care_eating_into_NJ_incomes.html

America's Uninsured Haven't Shown Collective Power (April 12, 2009)

<http://www.wtopnews.com/?sid=1647510&nid=106>

As Number of Uninsured Keeps Rising, Is Washington Ready to Act? (March 20, 2009)

<http://www.catholicnews.com/data/stories/cns/0901320.htm>

A Family Illness, and Fewer Friends Who Can Help (March 5, 2009)

<http://online.wsj.com/article/SB123620847691933901.html>

He Joined the Ranks of the Uninsured to Help Fight a Disease (January 16, 2009)

<http://www.washingtonpost.com/wp-dyn/content/article/2009/01/15/AR2009011504101.html>

Couple Finds Future Dim as Costs Rise, Home Value Falls (October 12, 2008)

<http://www.mcclatchydc.com/mainstreet/story/53826.html>

Post-Event Evaluation

Please complete this document prior to your departure. We will use it to see how well we did on this event, and how we may plan for further events. Your participation is appreciated!

PRIOR TO THIS SESSION:

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I already had an adequate understanding of issues about health care coverage and the church's role in ensuring health care coverage for all | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I had already: | | Yes | | No |
| a. participated in at least one discussion of these issues within my parish. | | <input type="checkbox"/> | | <input type="checkbox"/> |
| b. seen my parish develop plans to address health care needs within the parish | | <input type="checkbox"/> | | <input type="checkbox"/> |
| c. seen my parish develop plans to address health care needs within our community | | <input type="checkbox"/> | | <input type="checkbox"/> |
| d. developed plans (personally or through the parish) to address the issue of health care coverage for all at the national level | | <input type="checkbox"/> | | <input type="checkbox"/> |

AFTER THIS SESSION:

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I have a much better sense of the issues involved in health care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have a much better sense of how members of my parish may address health care needs within the parish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have a much better sense of how members of my parish may address health care needs within my community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I have a much better sense of how I and/or members of my parish may address health care coverage for all at the national level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I believe this is something that should be pursued further at the parish and/or the diocesan level. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please use space below and on the back of this sheet to provide us with comments you would feel helpful, such as telling us of particular successes or good things about this session, or ideas we could use to improve future sessions.

Thank you for attending and participating!

Session 3 Plan

What we can/should do

1. **Open with Prayer** (See listing of especially appropriate prayers in the [Resources](#) section at end of guide.)
2. **Set some guidelines** for the discussion. Here are some suggestions:
 - The only name I may use is my own name.
 - The words "always" and "never" are not allowed.
 - I will listen and not interrupt.
 - I will not blame, shame, or attack.
 - I will try to be patient.
 - I will think in a "both/and" manner, rather than in an "either/or" manner.
3. **Introductions** (5 minutes)
4. **Identifying the issues** (15 minutes)
 - a. Read Resolution C071 (if you have reviewed it at earlier sessions, you might recap it, focusing especially on the action steps under the second "Resolved.")
 - b. Show clips from the video *Health, Money & Fear* (each about 2 minutes) - especially recommended:
 - Introduction
 - Our Expectations
 - Rationing
 - Does it Reflect Our Values?
 - c. **Pose the following questions.** Invite responses. Record responses on newsprint. Brief responses would be best with debate and discussion limited.
 - What is the individual's personal responsibility for health?
 - What is my responsibility for the health of my family? My friends? fellow church members?
 - What is my responsibility for the health of those in my community?
 - What can/should we do about our national health care system?
5. **Turning to the Bible** (10 minutes) If the group is large, break into small groups to discuss and record answers on newsprint and report back to the larger group

Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your body.	I Corinthians 6:19-20
He who ignores discipline despises himself, but whoever heeds correction gains understanding.	Proverbs 15:32
No discipline seems pleasant at the time, but painful. Later on, however, it produces a harvest of righteousness and peace for those who have been trained by it.	Hebrews 12:11

- How do these Bible verses apply to our health?
 - Can you share other Bible verses that refer to health and personal responsibility?
 - How do these passages apply to our current health care system?
6. **Models for Health Care Organization** (10 minutes) - Briefly present the models of health care organization from the video "Sick Around the World" - or else models being discussed currently in the national health reform debate (for up-to-date information, see especially the Kaiser Family Foundation web site or the Rand Compare web site in the Resources section below.
 7. **The Role of the Church** (10 minutes)
 - What do you see as the role of the church today?
 - How do you see the church becoming involved in issues of health and healing today?
 8. You might close by offering a **way to contact federal legislators**: (It can be especially effective if you look up your local Representative & Senator.)
 - Write your U.S. Representative: <https://writerep.house.gov/writerep/welcome.shtml>
 - Write your Senator: http://www.senate.gov/general/contact_information/senators_cfm.cfm
 - Max Baucus (Chair, Senate Finance Committee): <http://baucus.senate.gov/>
 - Henry Waxman (Chair, House Energy and Commerce Committee): <http://waxman.house.gov/>
 9. **Close with Prayer** (See listing of especially appropriate prayers in the [Resources](#) section at end of guide.)

We would love to hear how your session went. Please have participants fill out the [questionnaire](#) attached and mail them (or your tally) to: Glenn C. Graber, 7308 Manderly Way, Knoxville, TN 37909

FINAL VERSION - Concurred

Resolution: C071
Title: Health Care Coverage for All
Topic: Health Care
Committee: 09 - National and International Concerns
House of Initial Action: Deputies
Proposer: Diocese of East Tennessee

Resolved, the House of Bishops concurring, That the 76th General Convention call on its congregations to undertake discussions within the parish of the issue of health care coverage in the United States, including:

- a) recognition that health is multi-dimensional, with spiritual, social, environmental, and mental elements as well as physical,
- b) reminder of personal responsibility for healthy life choices and concern for maintaining one's own health,
- c) proclaiming the Gospel message of concern for others which extends to concern for their physical health as well as spiritual well-being,
- d) responsibility as a parish to attend to the needs (including health-related needs) of others, both other members of the parish family and those of the wider community, the nation, and the world,
- e) recognition that there are limits to what the healthcare system can and should provide and thus that some uncomfortable and difficult choices may have to be made if we are to limit healthcare costs; and be it further

Resolved, That, The Episcopal Church urge its members to contact elected federal, state and territorial officials encouraging them to:

- a) create, with the assistance of experts in related fields, a comprehensive definition of "basic healthcare" to which our nation's citizens have a right,
- b) establish a system to provide basic healthcare to all,
- c) create an oversight mechanism, separate from the immediate political arena, to audit the delivery of that "basic healthcare,"
- d) educate our citizens in the need for limitations on what each person can be expected to receive in the way of medical care under a universal coverage program in order to make the program sustainable financially,
- e) educate our citizens in the role of personal responsibility in promoting good health; and be it further,

Resolved, That this resolution be distributed to all Provinces and dioceses of The Episcopal Church for their consideration and support.

EXPLANATION

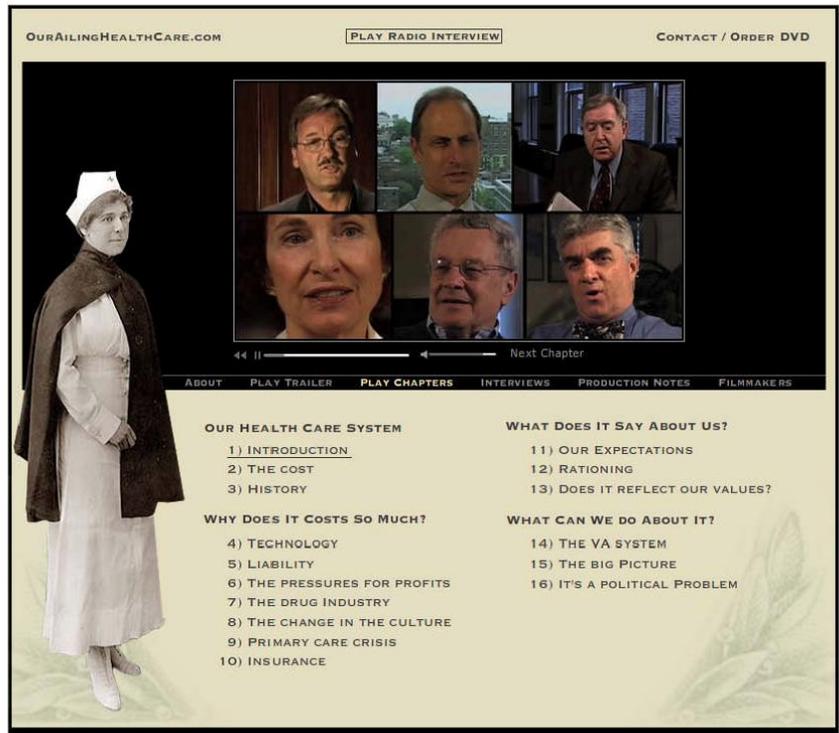
We, the members of the Bioethics Commission of the Episcopal Diocese of East Tennessee believe that:

- a) provision of basic healthcare for all is a duty of a nation of Judaic-Christian values and, furthermore,
- b) the current healthcare delivery system of the United States is flawed in failing to provide comprehensive coverage for 47 million of our citizens and, furthermore,
- c) our current system with its escalating costs represents a non-sustainable financial challenge to employers competing in a global market,
- d) the steps we specify above are all necessary to address this problem adequately.

Health, Money and Fear

<http://www.ourailinghealthcare.com>

"Our Health Care System is beyond broken or sick. It's dumb. We spend more than twice as much per capita than most developed countries, the taxpayer is already paying for 60% of the total bill, and, by any measure of public health, our results are poor. Driven by technology and fear of liability, physicians order tests and treatments without regard for cost. Patients and families embrace unreasonable expectations. Drug companies successfully market expensive drugs that, at best, are marginally more effective than less expensive, older ones. As our primary care providers continue to disappear, increasing fragmentation of care, costs will rise and outcomes will worsen. Most significantly, the insurance industry adds nothing to "health" and greatly to total cost, which is increasingly a burden to our economy and threat to the financial solvency of our government. What's more, our State governments are having to divert money to health care from education, infrastructure and protecting the environment, all of which may have more impact on the health of our society than access to a doctor."



Sick Around the World

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>

PBS' **FRONTLINE** teams up with veteran *Washington Post* foreign correspondent T.R. Reid to find out how five other capitalist democracies – the United Kingdom, Japan, Germany, Taiwan and Switzerland – deliver health care, and what the United States might learn from their successes and their failures.

"There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.

But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems"



United Kingdom

Percentage of Gross Domestic Product (GDP) spent on health care: 8.3

Average family premium: None; funded by taxation.

Co-payments: None for most services; some co-pays for dental care, eyeglasses and 5 percent of prescriptions. Young people and the elderly are exempt from all drug co-pays.

What is it? The British system is "socialized medicine" because the government both provides and pays for health care. Britons pay taxes for health care, and the government-run National Health Service (NHS) distributes those funds to health care providers. Hospital doctors are paid salaries. General practitioners (GPs), who run private practices, are paid based on the number of patients they see. A small number of specialists work outside the NHS and see private-pay patients.

How does it work? Because the system is funded through taxes, administrative costs are low; there are no bills to collect or claims to review. Patients have a "medical home" in their GP, who also serves as a gatekeeper to the rest of the system; patients must see their GP before going to a specialist. GPs, who are paid extra for keeping their patients healthy, are instrumental in preventive care, an area in which Britain is a world leader.

What are the concerns? The stereotype of socialized medicine -- long waits and limited choice -- still has some truth. In response, the British government has instituted reforms to help make care more competitive and give patients more choice. Hospitals now compete for NHS funds distributed by local Primary Care Trusts, and starting in April 2008 patients are able to choose where they want to be treated for many procedures.



Japan

Percentage of GDP spent on health care: 8

Average family premium: \$280 per month, with employers paying more than half.

Co-payments: 30 percent of the cost of a procedure, but the total amount paid in a month is capped according to income.

What is it? Japan uses a "social insurance" system in which all citizens are required to have health insurance, either through their work or purchased from a nonprofit, community-based plan. Those who can't afford the premiums receive public assistance. Most health insurance is private; doctors and almost all hospitals are in the private sector.

How does it work? Japan boasts some of the best health statistics in the world, no doubt due in part to the Japanese diet and lifestyle. Unlike the U.K., there are no gatekeepers; the Japanese can go to any specialist when and as often as they like. Every two years the Ministry of Health negotiates with physicians to set the price for every procedure. This helps keep costs down.

What are the concerns? In fact, Japan has been so successful at keeping costs down that Japan now spends too little on health care; half of the hospitals in Japan are operating in the red. Having no gatekeepers means there's no check on how often the Japanese use health care, and patients may lack a medical home.



Germany

Percentage of GDP spent on health care: 10.7

Average family premium: \$750 per month; premiums are pegged to patients' income.

Co-payments: 10 euros (\$15) every three months; some patients, like pregnant women, are exempt.

What is it? Germany, like Japan, uses a social insurance model. In fact, Germany is the birthplace of social insurance, which dates back to Chancellor Otto von Bismarck. But unlike the Japanese, who get insurance from work or are assigned to a community fund, Germans are free to buy their insurance from one of more than 200 private, nonprofit "sickness funds." As in Japan, the poor receive public assistance to pay their premiums.

How does it work? Sickness funds are nonprofit and cannot deny coverage based on preexisting conditions; they compete with each other for members, and fund managers are paid based on the size of their enrollments. Like Japan, Germany is a single-payment system, but instead of the government negotiating the prices, the sickness funds bargain with doctors as a group. Germans can go straight to a specialist without first seeing a gatekeeper doctor, but they may pay a higher co-pay if they do.

What are the concerns? The single-payment system leaves some German doctors feeling underpaid. A family doctor in Germany makes about two-thirds as much as he or she would in America. (Then again, German doctors pay much less for malpractice insurance, and many attend medical school for free.) Germany also lets the richest 10 percent opt out of the sickness funds in favor of U.S.-style for-profit insurance. These patients are generally seen more quickly by doctors, because the for-profit insurers pay doctors more than the sickness funds.



Taiwan

Percentage GDP spent on health care: 6.3

Average family premium: \$650 per year for a family for four.

Co-payments: 20 percent of the cost of drugs, up to \$6.50; up to \$7 for outpatient care; \$1.80 for dental and traditional Chinese medicine. There are exemptions for major diseases, childbirth, preventive services, and for the poor, veterans, and children.

What is it? Taiwan adopted a "National Health Insurance" model in 1995 after studying other countries' systems. Like Japan and Germany, all citizens must have insurance, but there is only one, government-run insurer. Working people pay premiums split with their employers; others pay flat rates with government help; and some groups, like the poor and veterans, are fully subsidized. The resulting system is similar to Canada's -- and the U.S. Medicare program.

How does it work? Taiwan's new health system extended insurance to the 40 percent of the population that lacked it while actually decreasing the growth of health care spending. The Taiwanese can see any doctor without a referral. Every citizen has a smart card, which is used to store his or her medical history and bill the national insurer. The system also helps public health officials monitor standards and effect policy changes nationwide. Thanks to this use of technology and the country's single insurer, Taiwan's health care system has the lowest administrative costs in the world.

What are the concerns? Like Japan, Taiwan's system is not taking in enough money to cover the medical care it provides. The problem is compounded by politics, because it is up to Taiwan's parliament to approve an increase in insurance premiums, which it has only done once since the program was enacted.



Switzerland

Percentage of GDP spent on health care: 11.6

Average monthly family premium: \$750, paid entirely by consumers; there are government subsidies for low-income citizens.

Co-payments: 10 percent of the cost of services, up to \$420 per year.

What is it? The Swiss system is social insurance like in Japan and Germany, voted in by a national referendum in 1994. Switzerland didn't have far to go to achieve universal coverage; 95 percent of the population already had voluntary insurance when the law was passed. All citizens are required to have coverage; those not covered were automatically assigned to a company. The government provides assistance to those who can't afford the premiums.

How does it work? The Swiss example shows that universal coverage is possible, even in a highly capitalist nation with powerful insurance and pharmaceutical industries. Insurance companies are not allowed to make a profit on basic care and are prohibited from cherry-picking only young and healthy applicants. They can make money on supplemental insurance, however. As in Germany, the insurers negotiate with providers to set standard prices for services, but drug prices are set by the government.

What are the concerns? The Swiss system is the second most expensive in the world -- but it's still far cheaper than U.S. health care. Drug prices are still slightly higher than in other European nations, and even then the discounts may be subsidized by the more expensive U.S. market, where some Swiss drug companies make one-third of their profits. In general, the Swiss do not have gatekeeper doctors, although some insurance plans require them or give a discount to consumers who use them.

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>



Health Care Systems - The Four Basic Models

There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.

But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems:

The Beveridge Model

Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.

Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style health care, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control.

The Bismarck Model

Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction.

Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model -- Germany has about 240 different funds -- tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides.

The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.

The National Health Insurance Model

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.

The single payer tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or

by making patients wait to be treated.

The classic NHI system is found in Canada, but some newly industrialized countries -- Taiwan and South Korea, for example -- have also adopted the NHI model

The Out-of-Pocket Model

Only the developed, industrialized countries -- perhaps 40 of the world's 200 countries -- have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die.

In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease.

In the poor world, patients can sometimes scratch together enough money to pay a doctor bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care.

These four models should be fairly easy for Americans to understand because we have elements of all of them in our fragmented national health care apparatus. When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany.

For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.

The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody. This is much simpler than the U.S. system; it's fairer and cheaper, too.

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>

Personal Responsibility for Health

Maintaining and improving our biggest asset – Health

- One person can make a difference. Get a yearly physical. Talk to your family, friends, and co-workers about health issues. Ask questions and encourage healthy habits.

Our American health system is based on treating illness and problems rather than wellness or prevention. When we follow through with recommended immunizations and preventative measures such as mammograms, pap smears, blood pressure checks, blood cholesterol checks, colonoscopies, and blood sugar checks, we can institute change to prevent more serious illness.

Don't ask for every test and scan available. Read and learn about illness that has been diagnosed. Some insurance companies have their own online sites to research disease. For medical information that can assist you to communicate with your physician and ask questions. Beware of blogs or fees for information. Not all are reputable. Go to trusted internet sites such as:

www.familydoctor.org
www.mayoclinic.org
www.medem.com
www.medlineplus.gov
www.healthfinder.gov

www.cdc.gov
www.kidshealth.org
www.cancer.gov
www.hivinsite.ucsf.edu

Take notes about your questions for your physician, write down instructions and be compliant with treatment plans

- Take action. Plant a garden. Exercise. Discuss healthy diets with your family and friends. Eat five servings of fruits and vegetables.
- Lead by example. Be a role model for your children and grandchildren. Stewardship of the body could include eating smaller portions of better foods. Participate in activities like hiking, bike riding, skating, canoeing.
- Have a vision. Set a goal for healthier living. Manage stress. Lose weight. Quit smoking. Increase your physical activity. Learn something new.

Health for Families and Friends

- Use tools available on line to keep a diary of your own and your families' medical records, immunizations, medications, etc. Share your knowledge and tools with your co-workers and fellow church goers.
- Set up classes at church or work to learn how to buy and prepare healthy foods. Encourage each other to keep up good habits. Share your successes and struggles. Pray for one another. Walk together. Sponsor a healthy living or exercise class at church or work.
- Discuss end of life issues with family before a crisis occurs. Tell your physician and your clergy what kind of care you want. Complete advance directive forms. Support family and friends so their needs aren't overwhelmed by the complexities of the medical system. Call Clergy to let them know when family is in the hospital or have an illness

What We Can Do For the System

- Be informed – How does our health system work? Read and discuss health care with each other.
- Engage in advocacy – We need people of faith to speak up and call for justice. Emphasize the moral imperative of health care for all. Patients have the right to refuse care also.
- Build Bridges - See value in others' perspectives. Approach debate with a willingness to compromise for the greater good.
- Offer Hope – Believe in positive change even in difficult times.
- Call and write your elected officials and let them know you want the same health care benefits that Congress has – no more, no less

Post-Event Evaluation

Please complete this document prior to your departure. We will use it to see how well we did on this event, and how we may plan for further events. Your participation is appreciated!

PRIOR TO THIS SESSION:

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I already had an adequate understanding of issues about health care coverage and the church's role in ensuring health care coverage for all | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I had already: | | Yes | | No |
| a. participated in at least one discussion of these issues within my parish. | | <input type="checkbox"/> | | <input type="checkbox"/> |
| b. seen my parish develop plans to address health care needs within the parish | | <input type="checkbox"/> | | <input type="checkbox"/> |
| c. seen my parish develop plans to address health care needs within our community | | <input type="checkbox"/> | | <input type="checkbox"/> |
| d. developed plans (personally or through the parish) to address the issue of health care coverage for all at the national level | | <input type="checkbox"/> | | <input type="checkbox"/> |

AFTER THIS SESSION:

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly agree | Agree | Disagree | Strongly disagree |
| 1. I have a much better sense of the issues involved in health care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have a much better sense of how members of my parish may address health care needs within the parish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have a much better sense of how members of my parish may address health care needs within my community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I have a much better sense of how I and/or members of my parish may address health care coverage for all at the national level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I believe this is something that should be pursued further at the parish and/or the diocesan level. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please use space below and on the back of this sheet to provide us with comments you would feel helpful, such as telling us of particular successes or good things about this session, or ideas we could use to improve future sessions.

Thank you for attending and participating!

Resources

Videos

Health, Money & Fear: A Film About Our Health Care System - produced by a physician in Oregon, this film features physician leaders, medical economists, and public policy wonks. You can view this film on the web or order a copy for an optional donation (recommended donation: \$25)
<http://www.ourailinghealthcare.com/>

Sick Around America - A 2009 Frontline Documentary looking specifically at problems with the U.S. healthcare system. <http://www.pbs.org/wgbh/pages/frontline/sickaroundamerica/>

Sick Around the World - A 2008 Frontline Documentary - T. R. Reid examines the health care system in five countries: United Kingdom, Japan, Germany, Taiwan, and Switzerland. He sees four basic models of care, each of which is represented in a different part of the U.S. health care system. You can view this video on the web, or order a DVD copy. <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>

Sicko - Michael Moore's controversial documentary critical of the U.S. health care system. Available on commercial DVD. <http://www.michaelmoore.com/sicko/index.html>

Vision and Voice: Faithful Citizens and Health Care - a video featuring a variety of religious leaders calling for health care reform. You can view the video on the web, download them to your computer, or order a free copy of a DVD. <http://www.visionandvoice.org/>

Web Sites

Alliance for Health Reform - nonpartisan group - Senators Jay Rockefeller & Susan Collins, co-chairs - features briefing book for journalists <http://www.allhealth.org/>

American Medical Association - professional association of physicians <http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/health-system-reform.shtml>

The Commonwealth Fund - gathers careful data about quality & access to healthcare
<http://www.commonwealthfund.org/Default.aspx>

Cover the Uninsured - a project of the Robert Wood Johnson Foundation - website features video- and audiofiles of individuals' experiences with the U.S. healthcare system - audiofiles can be downloaded onto your computer <http://covertheuninsured.org/>

Faithful Reform in Health Care - an ecumenical advocacy group <http://faithfulreform.org/> - To see policy statements from a number of religious groups, go to:
<http://www.fairfaithfulreform.org/index.php/Table/Theology-and-Policy/>

Families USA - a nonpartisan advocacy group for health care reform <http://www.familiesusa.org/>

The Galen Institute <http://www.galen.org/>

Kaiser Family Foundation - a wealth of information about federal and state health care policy -
<http://healthreform.kff.org/>

League of Women Voters http://www.lwv.org/AM/Template.cfm?Section=Health_Care1

National Coalition on Health Care - former Presidents Jimmy Carter & George Bush, co-chairs <http://www.nchc.org/>

Physicians for a National Healthcare Program - a coalition of physicians who favor a single payer system

<http://www.pnhp.org/>

Rand Compare (Rand Corporation) <http://www.randcompare.com/>

Robert Wood Johnson Foundation <http://www.rwjf.org/healthreform/>

Rock the Vote - an advocacy group aimed especially at teens and young adults

<http://www.rockthevote.com/issues/>

Tennessee Health Care Campaign <http://www.thcc2.org/>

UHCAN - Universal Health Care Action Network - links to many other advocacy sites

<http://www.uhcan.org/index.php>

Books and Articles

Howard Baker, Tom Daschle, Bob Dole, *Crossing Our Lines: Working Together to Reform the U.S. Health System* - available online at <http://www.bipartisanpolicy.org/ht/a/GetDocumentAction/i/10782>

Norman Daniels and James E. Sabin, *Setting Limits Fairly: Learning to Share Resources for Health* 2nd ed. (New York: Oxford University Press, 2008).

Tom Daschle, *Critical: What We Can Do About the Health-Care Crisis* (New York: Thomas Dunne Books, 2008)

Ezekiel Emanuel, *Healthcare, Guaranteed* (New York: Public Affairs, 2008).

Glenn C. Graber, John A. Eaddy, and Alfred D. Beasley, *Ethical Analysis of Clinical Medicine: A Guide to Self-Evaluation* - chapter 5: "Who Gets What?" - available on line <http://web.utk.edu/~ggrabber/GBE-TOC.htm>

Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* available online at http://www.nap.edu/catalog.php?record_id=12511

Ed Kashi and Julie Winokur, *Denied: The Crisis of America's Uninsured* (San Francisco: Talking Eyes Media, 2003).

William F. May, *Testing the Medical Covenant* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1996)

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care* (1983) - available online at http://bioethics.gov/reports/past_commissions/securing_access.pdf

President's Council on Bioethics, *Taking Care: Ethical Caregiving in Our Aging Society* (2005) available online at: http://bioethics.gov/reports/taking_care/index.html

Other

- Some especially appropriate prayers - Book of Common Prayer
 - A litany for healthcare - Faithful Reform
 - template for an interfaith prayer service - Faithful Reform
- Glossary of health reform terminology - Cover the Uninsured

Some especially appropriate prayers from “Prayers and Thanksgivings,” beginning on page 814 of the Book of Common Prayer:

20. For Congress or a State Legislature

O God, the fountain of wisdom, whose will is good and gracious, and whose law is truth: We beseech thee so to guide and bless our Senators and Representatives in Congress assembled (or in the Legislature of this State, or Commonwealth), that they may enact such laws as shall please thee, to the glory of thy Name and the welfare of this people; through Jesus Christ our Lord. *Amen.*

35. For the Poor and the Neglected

Almighty and most merciful God, we remember before you all poor and neglected persons whom it would be easy for us to forget: the homeless and the destitute, the old and the sick, and all who have none to care for them. Help us to heal those who are broken in body or spirit, and to turn their sorrow into joy. Grant this, Father, for the love of your Son, who for our sake became poor, Jesus Christ our Lord. *Amen.*

39. For those who Influence Public Opinion

Almighty God, you proclaim your truth in every age by many voices: Direct, in our time, we pray, those who speak where many listen and write what many read; that they may do their part in making the heart of this people wise, its mind sound, and its will righteous; to the honor of Jesus Christ our Lord. *Amen.*

57. For Guidance

Direct us, O Lord, in all our doings with thy most gracious favor, and further us with thy continual help; that in all our works begun, continued, and ended in thee, we may glorify thy holy Name, and finally, by thy mercy, obtain everlasting life; through Jesus Christ our Lord. *Amen.*

22. For Social Service

O Lord our heavenly Father, whose blessed Son came not to be ministered unto but to minister: Bless, we beseech thee, all who, following in his steps, give themselves to the service of others; that with wisdom, patience, and courage, they may minister in his name to the suffering, the friendless, and the needy; for the love of him who laid down his life for us, the same thy Son our Savior Jesus Christ, who liveth and reigneth with thee and the Holy Spirit, one God, for ever and ever. *Amen.*

See Also “Prayers for the Sick” beginning on p. 458 of the *Book of Common Prayer*.
For contemplative prayer, focusing on a word like “sick” may be appropriate.

A Litany of Prayer for the Uninsured and Under-Insuredⁱ

Reader #1: We are the millions of men and women in our national community who—for a variety of reasons: downsizing, outsourcing, restructuring—will wake up one day this year to learn that we no longer have a job. Added to the stress of finding a new job, we'll also have to figure out how to continue to provide health care for our families. If we are fortunate to have health insurance, we will be faced with paying more at a time when we are trying to make do with less.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #2: We are the 4 million people in our national community who will celebrate a 19th birthday this next year. As we blow out the candles on the cake, we may be marking the loss of our health insurance. Our society will ensure that if we call the fire department, someone will respond. It will not offer us the same guarantee for our health.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #3: We are the 5 million children in our national community whose lack of health insurance sets up a barrier to good health. We are children in a nation that works to make sure we each have a basic education. We are children in a nation which ignores that we need a similar guarantee for health care.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #4: We are the 30 million workers between the ages of 18 and 64 who earn less than \$9 an hour. Those of us who work full-time earn \$18,800 a year. Many of us are the store clerks, mechanics, dry cleaners, and restaurant workers you meet. Our nation relies on our work to keep American humming along. We typically have no health insurance. We make too much to get health care from public health programs. We often end up in emergency rooms for care because we have no other place to go.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

(over)

Reader #5: We are the owners of small businesses, those businesses with less than 100 workers. We employ 38 million people in communities across the country. We support the local little league team and sponsor civic events. Because of the high cost, we often are unable to provide the protection of health insurance for our employees.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #6: We are the six of every 10 people in the United States who are lucky enough to have jobs that offer health insurance for our families. And yet, each year, we find that we are paying more. Deductibles and co-payments keep going up. More and more things are not covered by our insurance, which means we have to pay for them. As a result, many of us—people who own homes, who had full-time employment and insurance before getting ill—will declare bankruptcy because of our medical bills.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #7: We are the 18,000 people who will die this year because we do not have the security of health care that comes with having insurance. Out of pride, out of shame, out of fear – or because we simply don't have the money to go to the doctor – we will ignore signs that our health may be in jeopardy. If we do get medical attention it will be too late.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

Reader #8: We are the uncounted millions for whom preventive health care and a healthy lifestyle are a struggle. We live in the inner city where fresh fruit and vegetables are not available in our markets. We live in rural communities with no doctors. The color of our skin or our gender disproportionately impacts the diagnosis and treatment of a medical condition.

Response: "You are or have been one of us. We know or have known others. We care for you and we pray for you, remembering that we are all brothers and sisters." (Moment of silence)

ⁱ Adapted from "Readings from the Uninsured" in "Vision and Voice: Faithful Citizens and Health Care," Session 1, accessed at <www.visionandvoice.org> Permission granted for printing with this citation.

Interfaith Prayer Service or Candlelight Prayer Vigil

Unison Prayer: In the sacred bonds of our common humanity, we give thanks for the life that we share and for our calling to care for each other. We acknowledge that we have failed to care for every member of our human family, and have not ensured that all may receive the health care they need for the life that you intend. We pray for forgiveness for hearts that have been slow to feel another's pain, for hands that have been still when caring touch was needed, and for voices that have remained silent while millions suffer for lack of health care. Amen.

Jewish Perspectives on Health Care

Teachings from Jewish scripture – Leviticus 19: "Do not stand idly by the blood of your neighbor." Judaism advances two core values underlying an abiding commitment to provide health care to all of God's children. The first is that an individual human life is of infinite value; the second is that we are endowed with wisdom and strength to be God's partners in repairing the world. Just as the Talmud teaches that a physician is obligated to heal and that a patient is obligated to obtain health care, so too are we taught that the whole of society is responsible for ensuring that every individual has access to health care.

Prayer from the Jewish Tradition (to be offered by a Jewish participant or leader)

Unison Participant Response: Strengthen us to use our hearts, hands, and voices to raise our vision for a health care future that includes everyone and works well for all of us.

Reflection on Christian Perspectives on Health Care

Teachings from Christian Scripture – Mark 2:3: "Then some people came, bringing to *Jesus+ a paralytic, carried by four of them... He said to the paralytic, 'I say to you, stand up, take your mat and go to your home.'" Christian scripture is filled with Jesus' acts of healing, but this particular scripture also lifts up our responsibility in helping others access the care they need. We are reminded that all of the stories about Jesus' healing ministry were found in larger narratives about our common humanity, compassion, human dignity, shared responsibility, and God's intention for our health and wholeness.

Prayer from the Christian Tradition (to be offered by a Christian participant or leader)

Unison Participant Response: Strengthen us to use our hearts, hands, and voices to raise our vision for a health care future that includes everyone and works well for all of us.

Reflection on Islamic Perspectives on Health Care

Ayahs from the Holy Qur'an. "A person whose passions respond only to his or her personal needs, and who is only concerned with his or her own personal and familial life, has long abandoned the true purpose of life..." (15:3). True Muslims are compassionate human beings, whose passions are aligned with a divine purpose of life. It is a pleasure for Muslims to help address health care needs, for piety is achieved in giving what you love most to those who need you.

Prayer from the Islamic Tradition (to be offered by a Muslim participant or leader)

Unison Participant Response: Strengthen us to use our hearts, hands, and voices to raise our vision for a health care future that includes everyone and works well for all of us.

Silent Meditation

Unison Participant Response: For the blessing of life, we give you thanks. For the comfort you provide for all who experience illness and loss, we give you thanks. And for the call to care and the will to do it, we give you thanks. Amen.

Faithful Reform in Health Care
3000 Euclid Avenue ~ Cleveland, OH 44115 ~ www.faithfulreform.org ~ 216.325.0010



Glossary

- A**
- Acute Care:** Medical treatment given to individuals whose illnesses are short-term or episodic.
- Acute Condition:** An illness or condition that is short-term or episodic. Examples would include a case of bronchitis or a broken arm.
- Aid to Families with Dependent Children (AFDC):** A state-based federal assistance program that provided cash payments to needy children (and their caretakers), who met certain income requirements. AFDC has now been replaced by a new block grant program.
- B**
- Beneficiary:** A person who is eligible for or receiving benefits under an insurance policy or plan.
- C**
- Cafeteria Plan:** Health benefits that are excludable for income and employment tax purposes. Under a cafeteria plan, an employee is provided a fixed budget to purchase various benefits such as health, life and disability.
- Catastrophic Health Insurance:** Health insurance that provides fairly complete coverage against the high cost of treating severe or lengthy illnesses or disability, usually with little or no coverage for relatively minor expenses.
- Centers for Medicare and Medicaid Services (CMS):** Formerly known as the Health Care Financing Administration (HCFA), the Centers for Medicare and Medicaid Services is the federal agency that administers Medicare and works in conjunction with state governments to oversee the federal-state Medicaid and the State Children's Health Insurance Program (SCHIP).
- CHAMPUS:** (Civilian Health and Medical Program of the Uniformed Services) A health plan that serves the dependents of active duty military personnel and retired military personnel and their dependents.
- CHIP:** (Children's Health Insurance Program) A federal-state program enrolling children from families that earn too much to qualify for Medicaid but not enough to afford private health insurance. *[Note: formerly called SCHIP.]*
- Chronic Care:** Treatment or services necessary to treat a medical condition that lasts a lifetime or recur.
- Chronic Condition:** A medical problem that will not improve, that lasts a lifetime, or recurs and usually requires a long period of supervision, observation or care. Examples include diabetes, asthma and high blood pressure. *[NOTE: many say "chronic" means it will last a year or more.]*
- Co-insurance:** The percentage of a medical bill that is not covered by a patient's health policy and must therefore be covered out-of-pocket by the patient.
- Co-payment:** The part of the medical bill that is not covered by a patient's health insurance policy and must be covered out of pocket by the patient. It is usually a flat amount, such as \$10 for an office visit.
- COBRA:** (Consolidated Omnibus Budget Reconciliation Act of 1985) A federal law that allows individuals leaving a company with 20 or more workers to continue the health insurance policy they had when employed. COBRA applies when individuals lose or leave a job. The individual pays the entire group premium, not just the worker's share, plus a set administrative fee, usually for up to 18 months.
- Collectively Bargained Health Plan:** An employer provided benefit, pension or annuity plan that is established through a union-negotiated contract.
- Community Rating:** A method for setting health insurance rates in which everyone in a specific area is charged the same premium rather than having it adjusted individually according to a person's health history. The rate is usually based on the average cost of delivering health care to people living in that area.
- Coverage:** A person has coverage if all or part of his

health care costs is paid either by insurance or by the government.

D

Deductible: The amount of money, or value of certain services (such as one physician visit) a patient or family must pay before costs are covered by the health plan or insurance company, usually per year.

Diversion: The routing of patients to other hospitals because an emergency room is full.

E

Employment Retirement Income Security Act (ERISA): A law enacted in 1974 that sets federal reporting and disclosure rules for employer-sponsored health plans. Under ERISA law, companies that self-insure and pay for workers' health benefits directly are exempt from state insurance regulation and taxes.

Exclusion Period: A period during which a health insurance plan will not pay for a new enrollee's health care relating to a previous medical condition.

Experience Rating: A practice in which premium rates for health insurance are based on the past cost experiences of the enrolled individual or group.

F

Federal Employees Health Benefit Program (FEHBP): The health benefit system for federal civilian employees. Under the FEHBP, employees choose from among multiple health plans approved by the federal government. The federal government picks up a large portion of the cost of coverage.

Federal Poverty Guidelines: The official annual income level for poverty is defined by the federal government. Under the 2003 guidelines, the federal poverty level for a family of four was \$18,400.

Fee-for-service: An approach in which physicians or other providers bill separately for each patient encounter or service they provide, rather than receiving a salary or a set payment per patient

enrolled.

Flexible Spending Account: Also Flexible Spending Arrangements. Benefit plans in which an employer reduces an employee's earnings, before income tax is taken out, to pay for medical expenses not covered by insurance. These plans also can be used to pay for child care services.

G

Group Insurance: Health insurance offered through business, union trusts or other groups and associations. This system of health insurance is the most common in the United States.

Guarantee Issue: A requirement in which health plans must enroll people regardless of health status, age, gender or other factors predicting use of health services. However, plans that provide guaranteed issue can turn enrollees away for other reasons.

Guarantee Renewability: When a health plan has a guaranteed renewability clause, it prevents coverage from being discontinued because a person gets sick.

H

Health Insurance Portability & Accountability Act: HIPAA. A federal law enacted in 1996, offering limited protections to ensure continuity of health care coverage. Under HIPAA, insured individuals who have a health condition cannot be denied benefits when they change jobs. It also prevents health plans from refusing coverage on the basis of pre-existing conditions. But HIPAA puts no limits on premiums that may be charged.

Health Maintenance Organization (HMO): A health plan, either for-profit or not-for-profit, that provides comprehensive medical services to its members for a fixed, prepaid premium. Members must use participating providers and are enrolled for a fixed period of time.

I

Indemnity Insurance: A system of health insurance in which the insurer pays for the costs of covered services after care has been given, on a fee-for-service basis. It usually defines the maximum amounts that will be paid for covered services.

Individual Health Plan: Health policies for people not connected to an employer or other group. This term also refers to coverage purchased by self-employed persons who have no other employees. (Sometimes called “non-group.”)

M

Managed Care: Any health insurance that controls the use of health services by its enrolled members in order to contain health care costs, improve the quality of care or both. Examples are health maintenance organizations (HMOs) and Preferred Provider Organizations (PPOs).

Medicaid: The federal-state program for certain categories of low-income people that covered health and long-term care services for 51 million Americans in 2002, including children, the aged, blind, disabled and people who are eligible to receive federally-assisted income maintenance payments.

Medical Savings Accounts (MSAs): A tax-exempt account, similar to an Individual Retirement Account, that is used to pay for routine medical expenses. These are used to pay for health care not covered by insurance, including deductible and co-payments.

Medicare: The federal health insurance program for people age 65 and older, persons with disabilities and people with end-stage renal disease, with about 41 million beneficiaries in 2003.

Multiple Employer Welfare Arrangement (MEWA): A type of employee benefit plan that is established or maintained for the purpose of offering or providing certain types of benefits, including health benefits, to the employees of two or more employers. As provided under ERISA, states may regulate fully-insured MEWAs. They also may regulate self-insured MEWAs to the extent not inconsistent with federal law.

O

Out-of-pocket Expenditures: The portion of medical expenses a patient is responsible for paying.

Outpatient Care: Health care services that do not require a patient to receive overnight care in a hospital.

P

Pre-existing Condition: A medical condition a person develops before applying for a particular health insurance policy that could affect their ability to get coverage or how much they have to pay for it.

Preferred Provider Organization (PPO): A managed care plan that contracts with networks or panels of providers, which furnish services and are paid according to a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use non-network providers as well.

Premium: An amount paid periodically (usually monthly) to buy health insurance coverage.

Purchasing Pools: Through these pools, businesses and associations band together to negotiate lower premiums from health insurance plans than they could on their own.

R

Refundable Tax Credit: A type of tax credit sometimes used to help people purchase insurance. It is used to offset other taxes or is paid to a household even if there is no tax liability.

S

Safety Net Providers: Providers who have a mandate or mission to deliver large amounts of care to uninsured and other vulnerable patients. Examples include community health centers, clinics, public hospitals and some teaching hospitals.

SCHIP: (State Children's Health Insurance Program) A federal-state program enrolling children from families that earn too much to qualify for Medicaid but not enough to afford private health insurance. *[Note: Renamed CHIP in 2009.]*

Self-employed Deduction for Health Insurance: Self-employed taxpayers can deduct portions of their payments for health insurance when figuring their annual income for tax purposes. As of 2003, self-employed persons are able to deduct the full cost of insurance payments.

Self-insured Health Plan: Employer-provided health insurance in which the employer, rather than an

insurer, is at risk for its employees' medical expenses.

Stop-loss: An annual limit or cap on how much in deductibles and co-payments the patient has to pay.

T

Tax Credit: Under some health care reform proposals, an amount subtracted from one's tax liability to help them buy health insurance in the private market. The amount of the credit could vary according to age, health status or income. It could be paid even to those who owe no taxes ("refundable") and could be paid even before the person files a tax return ("advanceable").

Tax-favored Fringe Benefit: Under federal tax law, employer-paid health benefits are treated as a deductible business expense for the employer and not as taxable income for the worker.

Temporary Assistance to Needy Families (TANF): Block grant program that replaced Aid to Families with Dependent Children.

U

Uncompensated Care: Health care provided to persons unable to pay and not covered by private or governmental health insurance plans; includes both unbilled charity care and bad debts (services billed but not paid).

Underinsured: Refers to people who have some type of health insurance, such as catastrophic care, but not enough insurance to cover all their health care costs.

Uninsured: People who lack health insurance of any kind.

V

Veterans Health Care: Health care provided by the Department of Veterans Affairs to eligible veterans and to members of veterans' families and survivors of deceased veterans.

W

Waiting Period: The period from which a person is deemed eligible for health insurance coverage to the date that coverage becomes effective.