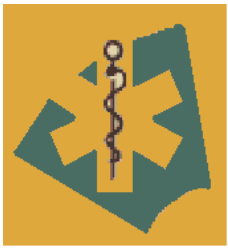
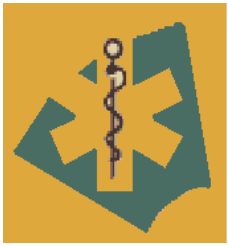


Theological Statement on Health Care

Los Angeles Council of Religious Leaders
Health Care Task Force



In 2003, the Los Angeles Council of Religious Leaders, representing a broad spectrum of Jewish and Christian communities in Southern California, convened a Health Care Task Force, whose charge was to study the crisis in health care coverage and to suggest remedies appropriate for these religious groups to support. Over the last year and a half the task force has met with many of the stakeholders in this issue—hospital and health plan executives, health activists, providers, public health scholars, elected officials, and theologians. This report represents their conclusions.

Our traditions call us to **protect the well-being of every human life** because we are created in God's image. As a nation, we have failed to meet that duty because we permit people to suffer and die for lack of health care. Furthermore, our traditions call us to be good **stewards** of our health care resources. But we have failed here too. Even though in the United States we spend far more than other industrialized nations on health care, we rank behind these other countries in major health indices. Why? We identified three major failings within the health care system in the US—***high administrative costs*** of private health plans, high costs of ***pharmaceuticals***, and ***misuse of medical technology***. We concluded that private health care companies have not only failed to solve these problems, they have made them worse.

We cannot tolerate the **injustice** that leaves millions of our fellow citizens without means to pay for health care, many for all of their life, and most for some part of their lives. Failing to obtain preventative care, many delay seeking help until their disease is grave or deadly. Those who need health care and attempt to pay for all or part of it often crumble under the weight of huge bills.

We believe that health care must be ***universal, continuous, affordable*** to consumers, ***sustainable*** for society, and designed to ***enhance health and well-being***.

Our goals are obtainable. We could deliver effective health care and meet these goals with funds currently being spent in the health care marketplace. Although good private, non-profit health plans exist, we conclude that the government alone can set priorities and ensure a comprehensive health plan for all.

Therefore, we call our congregations to **study** the issue of health care. We call upon them to **advocate** for legislation that addresses the concerns of stewardship and justice. And we call upon local congregations to **develop initiatives** that address the health care crisis in their communities. As the Council of Religious Leaders, we will lead the way.

The Los Angeles Council of Religious Leaders
Health Care Task Force
March 2005

Introduction: The Health Care Task Force

In December, 2003, the Los Angeles Council of Religious Leaders—heads of middle judicatories from a broad spectrum of Jewish and Christian communities in Los Angeles and Southern California— took note of the fact that California is the epicenter of the nation's growing crisis in health insurance coverage. The Council created a Health Care Task Force to study this situation, and, ultimately, to speak about it from the perspective of the region's religious conscience.

Led by the Right Reverend J. Jon Bruno, Bishop of the Episcopal Diocese of Los Angeles, and Rabbi Mark S. Diamond, Council Chair and Executive Vice President of the Board of Rabbis of Southern California, the task force met for more than a year. It surveyed public health reports. It met with hospital and health plan executives, health care providers, community advocates, health care economists, legislators, ethicists, and theologians. It engaged in a series of discussions to assess whether or not Southern California's diverse faith communities did in fact share moral beliefs about the design of their nation's and state's health coverage system.

Members of the task force quickly reached consensus.

- They agree that our nation's economic and political institutions, by and large, have not been good **stewards** of the resources that our society allocates to health care. Disparities in health care coverage raise serious questions about the overall **justice** of our present system.
- They agree that religious communities have a special obligation to address health care access issues. They believe that our traditions call us to speak aggressively on behalf of our communities—indeed, on behalf of our own congregations—where many people have experienced life-threatening barriers to securing adequate health care coverage.

Therefore, the Health Care Task Force developed a Call to Action. We urge the region's faith communities to engage in learning about our health care system, to become knowledgeable advocates for the various options that legislators might adopt to reduce our health care system's inequities, and to support legislators who are trying to find solutions to our health care crisis.

In Spring 2005, the Health Care Task Force submitted the following statement to the Los Angeles Council of Religious Leaders:

I. The Crisis in Health Insurance Coverage

Our nation's system of health care coverage is broken.

Americans allocate more money to health care than any other nation in the world. Our hospitals use expensive, sophisticated equipment. Many individuals and families who are covered by health insurance receive services that are first-rate. Meanwhile, many others are underinsured, and still others lack any health insurance protection at all.

Virtually everyone agrees that our health insurance system is desperately in need of reform. Here are some indicators:

- Over forty million people living in the US are uninsured. In California, approximately one out of five people are uninsured for some period of time every year and in Los Angeles County one in four are uninsured. Persons of color—Latinos, Asians/Pacific Islanders, and African Americans—are disproportionately represented in those numbers.
- The uninsured receive too little medical service and receive it too late, and receive poorer care when they are in hospitals.
- One in seven American families has trouble paying medical bills. Medical bills were cited as a factor in half of all filings for personal bankruptcy in 2003.
- Over 80% of the uninsured are in working families.

The rapid rise in health spending in the US consumes nearly one fourth of our nation's economic growth. But, according to leaders of two major health care organizations, large segments of our care system are stunningly inefficient and rigidly unfocused.

Per capita health expenditures keep rising, yet fewer people have access to health care. We are caught in a vicious cycle. Rising costs and uncompensated care cause providers to charge more. Rising costs force health insurers to charge employers more, causing employers to shift costs to employees or drop coverage altogether. Government reimbursement rates for providers remain stagnant or decline, causing providers to refuse Medicare and Medicaid patients. More and more people become uninsured, driving the cost of uncompensated care higher.

II. Health Access and the Religious Conscience

This situation offends the conscience of Southern California's Jewish and Christian communities. Deeply held convictions—grounded in the shared Jewish and Christian scriptures, the Talmud, and the New Testament—lead us to denounce the inequities within America's fragmented health care coverage system.

As people of faith, we believe that:

A. The life of every human being, created in the image of God, is uniquely precious and worthy of being safeguarded.

Human beings are created in the image of God. Thus, human lives have an extraordinarily high value. In Genesis we read, "God created man in the image of himself, in the image of God he created him, male and female he created them" (Genesis 1:27). We interpret this to mean that each and every human being represents a unique reflection of God and that each human life is sacred and uniquely precious.

In the Jewish tradition, preserving human life and well-being (*pikuach nefesh*) is a religious duty of such high order that it takes precedence over every ritual duty and almost every other moral obligation (Talmud Bavli, Yoma 82a-83a). In the Christian tradition, Jesus teaches that a good neighbor is "the one who shows mercy" to a stranger whose life is endangered (Luke 10:37). Both faiths recognize a religious duty to come to the aid of persons whose lives are endangered. We understand the commandment "Do not stand on the blood of your fellow" (Leviticus 19:16) to demand not only that we not stand idly by while a person is bleeding before our eyes, but, more generally, that we accept responsibility for preserving human life and well-being in our society by all appropriate means.

Providing health care for all persons is one aspect of the duty to preserve human life. Scripture hints at this duty by assuming that medical care will be utilized when needed (Exodus 21:19), and pictures God asking plaintively, "Is there no balm in Gil'ad? Is there no physician there? Why then is the health of my people not restored?" (Jeremiah 8:22). Jesus, throughout his ministry, healed the sick, going out of his way to touch those most socially ostracized for their diseases.

Since each of us and all of us collectively have an obligation to **preserve the life and well-being** of every member of the human community, we must support actions that ensure that every person has access to health care. Every person enjoys a right to adequate health care, regardless of ability to pay for that care. When the lives and well-being of tens of millions of uninsured and under-insured people are endangered by lack of access to health care, we fail in our obligation to safeguard and uphold the sanctity of human life and we jeopardize the health of the entire community.

B. Each of us, as partners with God our Creator, has a responsibility for stewardship, especially for stewardship of those resources that protect the well-being of human lives.

From the first moment of the creation of humanity, God has charged us with the responsibility to be stewards of creation. This charge is reflected in both Genesis creation stories. In the first, humanity is commanded to "fill the earth and conquer it, and rule over" all that live upon it (Gen. 1:26). In the second, the first human is placed in the Garden of Eden "to work it and to keep it" (Gen. 2:15). We understand these stories to place upon humanity as a whole—and each human being individually—a responsibility to nurture and protect all of creation. Because of the unique preciousness of human life, this responsibility reaches its highest level in the stewardship of resources that could enhance the well-being of every person. We are called to be wise **stewards** of our health care resources.

Without a doubt, the American health care sector produces cutting edge medical research and—for those with access—provides an unequalled capacity to diagnose and treat illness. However, this success should not blind us to the system's failures. It fails to be a good steward of our nation's health care resources when Americans spend two to three times as much per person as other industrialized countries, yet overall health outcomes are worse.

In 2002, the US spent approximately $5000 per person for health care. This would be money well spent if we were buying compassionate, effective, timely preventive and curative health care for every man, woman and child, fulfilling our expressed belief that the life of every person is equally valued. Instead, every day, millions of people are suffering and dying because they cannot get the health care they need. Close to 44 million people in the US lack health insurance, and many more are underinsured or unreliably insured. For many, health care is delayed as long as possible, and when finally obtained, it is often poor quality care.

Economists have established a ratio between national wealth and health expenditures. As we might expect, populations in wealthier nations are healthier. Also, among industrialized countries, there is a predictable relationship between Gross Domestic Product (GDP) and expenditures on health care. The US is the exception. Instead of spending modestly more per person than countries such as Australia, Japan, the United Kingdom and Germany, we spend much more. We spend two to three times as much as other industrialized countries, almost 15% of our GDP. About half of these expenditures are paid for by public money.

Many factors contribute to the wasteful way that American health care dollars are spent. Three of the largest factors are:

- **Administrative costs.** In government health care in the U.S., administrative costs for programs such as Medicare and the VA health system are in the range of 3% to 5%, comparable to those of health care in other industrialized countries. Administrative costs of HMOs in the U.S., on the other hand, average around 12%, while

administrative costs for traditional non-group health insurers are often an astonishing 30% or even higher. Overall, the paperwork burden in the U.S. is enormous—due mostly to the multiplicity of billing agents and payers and because patients frequently, and often involuntarily, must change insurers or providers. Adding to the inefficiency is the surprisingly limited use of automated medical record systems.

- **Pharmaceuticals.** In the U.S., drugs are enormously expensive and vastly overused. In part, this is because Americans have been led to believe that there will always be a pill (or shot, spray or cream) that can solve their medical need. Advertising causes patients to demand the latest drug, which is often only marginally more effective than older and less expensive drugs but has a much higher profit margin. In addition, we pay up to ten times as much for exactly the same drug as in other countries because our relatively small and competing purchasers are unable to negotiate lower prices. In the U.S., drug companies charge what the market will bear because they can.

- **Medical technologies.** Expensive medical technologies undeniably save lives and relieve suffering, but access is uneven: inadequate in some communities and redundant in others. Hospitals and private specialty clinics compete for well-insured patients by advertising that they offer the latest in medical technology. Worse yet, for a variety of reasons—patient demand, doctors' reluctance to deny hope, or institutional efforts to stretch profit margins—expensive medical technologies are often used when they are not needed and cannot help. A recent study estimated that 30% of all health care dollars in the U.S. were spent on inappropriate care.

These three factors are the direct result of a health care system that is a for-profit, competitive enterprise. Insurance companies and pharmaceutical companies must prioritize maximizing the return to their shareholders. Hospitals and clinics must compete with other providers to survive, even if that competition leads them to inefficient and wasteful practices. Private, for-profit health providers have proved that they cannot be wise stewards of our nation's health care resources. But there are other factors that disproportionately drive up the cost of health care in this country. Our failure as a society to prioritize health causes additional inefficiencies and waste of our health care resources:

- **Failure to Provide Preventive Care.** Although almost everyone agrees that timely preventive care, including immunizations, regular physicals, healthful changes in the environment and better individual choices, would significantly reduce health care costs and improve the quality of people's lives, there are limited incentives for prevention. Individuals are poorly informed about what they can do to protect their health, especially those who lack a regular source of health care. Rushed

providers have time to focus only on acute problems. Frequently changing insurers and providers leaves no financial motivation to make the long-term investment in health promotion and disease prevention, leaving patients with uneven care. Furthermore, as a nation we are moving away from creating a healthy environment and lowering work-related risks. All these conditions increase the number of patients who develop serious illnesses that are expensive to treat.

- **Emergency Rooms.** Increasingly hospital emergency rooms are being used by the uninsured as a source of primary care because they have no place else to turn and emergency rooms by law cannot turn anyone away. This practice wastes resources because emergency room care is the most expensive cost center in the health care system. When patients present themselves to ER, the condition has usually reached an acute stage requiring more expensive intervention. After patients leave, ER physicians have no way to ensure follow up care. This results in primary care provided by the ER that is effective only in the short term, for which the uninsured person returns again for the same condition.

The current inadequacies and inequities in American health care coverage have economic as well as human costs. While, as people of faith, we are most concerned about the human welfare aspects, we also share a concern about the economic implications. The Institute of Medicine estimates that the economic value in healthy years of life that would be achieved by extending health insurance coverage to everyone in the U.S. would, under almost any set of assumptions, exceed the cost of providing coverage to those who currently lack it. Further, if the wasteful factors described above were eliminated or reduced, we could probably achieve universal coverage for less money than we currently spend, allowing more resources to flow to education, environmental protection, increased rates of saving, or other worthy pursuits.

This report recognizes that there are excellent models of private, non-profit medical care that are affordable to most working people. However, we also conclude that the best steward of health care rights and resources is the government. In a democracy, only a governmental structure responsible to its elected representatives can guarantee public policies that enable quality health care to all of society.

C. As people of faith, we are called to pursue justice, to practice love and compassion, and to advocate for the well-being of the poor and marginalized.

From the beginning of human communities where people worshiped God, we have been charged with the responsibility to create a just society: "Justice, justice shall you pursue" (Deut. 16:20). We are particularly commanded to actively concern ourselves with the welfare of the economically vulnerable. Isaiah chastises those who believe their highest

religious obligations to be the rituals of their tradition, and reminds us that the highest duties are to care for one another, including "to share your bread with the hungry, and bring the poor that are cast out to your house…" (Isaiah 58:7).

Those who hold wealth are commanded to share with those who do not in the biblical injunctions not to reap the corners of the fields or gather the gleanings of the harvests or to gather single grapes, but to leave these for the poor and the stranger (Lev. 19:9-10). In the Jewish tradition, this is not a matter of charity—the portion we are commanded to share actually belongs to the poor rather than to the "owner" (Mishnah Peah 7:5). In the Christian tradition, Jesus taught that caring for the poor and the sick is the equivalent of caring for God: "'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick…and go to visit you?' The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me'" (Matthew 25:37-40).

In both faith traditions we are called to have special concern for the stranger. The earliest attempts to define holiness called upon the faithful to protect those who are not like them: "And if a stranger lives with you in your land, you shall not wrong him. The stranger that lives with you shall be to you as the native among you, and you shall love him as yourself, for you were strangers in the land of Egypt" (Leviticus 19:33-34). In the Christian tradition, the Good Samaritan models mercy to the stranger by stopping to help and providing for his care (Luke 10:25-37). Much of Jesus' ministry was to society's outcasts, including his healing ministry to the lepers.

Thus, we have a high religious obligation to ensure that everyone in our society, especially the economically vulnerable and socially marginal, is treated with both **justice and compassion**. To deny health care—which preserves life—to people because they cannot afford to pay for it or because they are among the marginalized in society—people of color or immigrants – is repugnant not only to our understanding of the sanctity of human life, but also to our sense of justice and compassion, and to our obligation to safeguard the well-being of the most vulnerable in our society.

Most Americans, whether or not they are members of faith communities, are shocked when they understand the extent of inequities in health care access in this country. Poverty, language and cultural isolation, geography, and racial bias all create severe barriers to timely, affordable, safe, quality care. These barriers can only be addressed as part of a larger process of reducing disparities in our society. However, lack of health insurance is specific to the health sector. The uninsured population in the U.S. is huge, diverse and growing. It is easier to be uninsured than many think. Eight in ten live in working families. People lack insurance for reasons such as:

- Their employer does not offer health insurance, or they don't qualify because they haven't worked long enough, or they only work part time.
- The insurance offered by their employer is unaffordable given their salary level.
- Individual policies are too expensive and/or unavailable due to a pre-existing condition.
- Young adults lose parental coverage when they leave home or finish college.
- Spouses lose family coverage due to divorce, retirement, or death.

A small number of the uninsured (approximately 3%) are healthy and relatively wealthy, and may not suffer any negative consequences from their lack of health insurance. For the vast majority of the uninsured, however, the result is less health care and worse health outcomes. People without health insurance:

- Get fewer preventive screenings such as mammography and prostate exams.
- Are much less likely to get regular prenatal check-ups.
- Are hospitalized more for complications of chronic conditions such as diabetes, hypertension, pneumonia and ulcers.
- Have less access to equipment such as hearing aids and wheelchairs that allow them to live independently and with some dignity.
- Have later diagnoses for and higher risk of premature death from cancer, heart disease, diabetes, mental illness and many other conditions.

The central problem is that health insurance in the U.S. is voluntary, fragmented, and expensive. This creates great disparities in access to coverage and health care, leaving lower-income groups politically isolated in chronically under-funded health clinics and hospitals, geographically isolated with no access to timely care, and/or receiving occasional, uncoordinated care with real risks of treatment errors.

Medical debt exacerbates these disparities. One in seven American families has trouble paying medical bills. Medical bills were cited as a factor in half of all filings for personal bankruptcy in 2003. Even for families with health insurance, the requirement to pay higher shares of increasingly costly premiums, to take larger deductibles, and to make bigger co-payments for each visit and prescription puts them one major illness away from financial insolvency. Those hardest hit are the working poor (families of four with annual incomes of $18,400 to $36, 800), 22% of who had difficulty paying medical bills last year. There are health consequences as well as economic ones. Families carrying significant medical debt tend to delay seeking needed care. They particularly skip or reduce purchase of needed medications.

The problems in California are more severe than they are nationally, and even worse in Los Angeles County than elsewhere in California. California's un-insurance rate of 21% is one of the highest among large states. Los Angeles is at the epicenter of the national problem, with over 2 million residents who are uninsured at some time during the year, representing 1 in 4 of the county's non-elderly population. Furthermore, Latino and Asian/Pacific Islander people in Los Angeles are even more at risk: more than three times more likely to be uninsured than non-Latino whites.

Given the structural deficit of California's state budget, there is a real risk that the already bad situation will get worse for the 6.6 million uninsured Californians and a similar number cared for through the MediCal and Healthy Families programs. In the near future they are likely to:

- Have less access to affordable, employer provided health benefits.
- Have more difficulty finding providers willing to treat them (already 56% of MediCal patients report difficulty finding a doctor).
- Find the few remaining free clinics closing, and increasing numbers of emergency rooms closed or on diversion.

This report recognizes that the fundamental injustice in the health care delivery system in the U.S. is due to a complex set of factors: the multiplicity of insurance plans, the inability to secure insurance coverage, medical debt, uneven health care, ethnic or language isolation, lack of health system access – these are all the causes of health care injustice. And the situation is getting worse. The percent of uninsured persons increases annually as do per capita health care costs. As communities of faith, we draw upon the teachings of our foundational scriptures and on our traditions of concern for those in need to urge our congregations to call upon our legislators to address this health care crisis, and to insure that everyone receives timely, affordable, safe, quality health care.

III. Principles for Action

Each year legislators in Congress and in the California legislature propose laws that attempt to address inequities in our nation's and state's health insurance coverage. For example, recently in California (2004-2005), several legislators have advanced a single-payer proposal that would assure coverage for all Californians. This report employs a set of principles that members of our congregations can use in evaluating these proposals at the state and federal levels.

These principles are taken from "Insuring America's Health: Principles and Recommendations," a report by the Institute of Medicine evaluating the human consequences of the nation's current coverage crisis.

These fundamental principles are:

- Health care coverage should be **universal**—everyone in America should have access to timely, affordable, safe, quality health care.
- Health care coverage should be **continuous**—available to all in a way that provides preventive health services.
- Health care coverage should be **affordable**—any proposal must enable individuals and families at any income level to receive care.
- The health insurance strategy should be **affordable and sustainable for society**—realistic, cost-effective and controlling for inflation.
- Health insurance should **enhance health and well-being**—promoting access to high quality, patient-centered care that emphasizes prevention.

This report concludes that the only way to meet these criteria and effectively address the health care crisis in this country and California in particular is through government intervention, specifically through legislation developed by the elected representatives of our nation and state. We believe that government can no longer shirk its responsibility to align the conflicting and overlapping elements of a chaotic system and to bring stakeholders into a comprehensive system of quality health care for all.

IV. A Call to Action

This report asks the Council of Religious Leaders to make the following Call:

We demand justice in our health care system. We demand stewardship of health resources that meets the needs of individuals and neighborhoods across our land. We demand that our nation develops a health care system that safeguards the preciousness of every human being in God's creation. Health care coverage must be for everyone. The religious conscience will accept nothing less.

Therefore, the Los Angeles Council of Religious Leaders supports the efforts of members of Congress and of the California legislature who are attempting to develop health care coverage for all.

We will create channels of communication to assure that information concerning legislative efforts gets distributed in our own faith communities.

We will explore ways to create and support interfaith programs in our region that serve persons who are currently being passed by or who are underserved by the existing health coverage system.

Likewise, the Los Angeles Council of Religious Leaders urges participants in our region's religious organizations to:

A. Organize and advocate for legislation that provides health care coverage for all.
The region's religious organizations and allied community groups will create long-term, well-organized networks to support proposed legislation that: (1) makes health care coverage available for everyone living in our state and/or nation; (2) provides continuous and comprehensive health care; (3) provides insurance that is affordable for individuals and families, and, (4) that is affordable for our state and nation; and (5) provides access to high quality, patient-centered health services.

B. *Create curricula and educational programs that will equip participants to understand and to critique alternative public policy proposals that are intended to expand health care coverage.*
Public policy models are often complex. Understanding them requires information and analytic skills that can best be promoted by well-crafted curricula, taught by well-prepared facilitators. The California Council of Churches' program, "Being the Good Samaritan: Health Access for All Californians," is a good example of what is needed – a program that provides information about our current health coverage crisis, that provides information about alternative public policy models, and that offers opportunities for participants to speak together about the values of health care justice. We encourage leaders of our region's faith communities and civic organizations to take note of this program and to develop curricula that are appropriate to their own theological traditions and/or to their own organizational missions.

C. Advocate in their regional and national faith community organizations.
We urge individual congregations to advocate for resolutions in their regional and national denominational organizations that are based on these principles and which support legislation that carries out these principles. Likewise, we urge community and single-issue groups belonging to regional or national organizations to present resolutions at the regional and national levels.

D. Prioritize health care in the life of the congregation.
While advocating for major change in our health care system, congregations can also act to ameliorate the harm caused by the health care crisis. They can first look to their own practices, ensuring that they provide affordable health care coverage to all employees. Furthermore, they can create and participate in programs and projects such as the following:

a. Provide information about health coverage resources that are currently available—e.g., MediCal, Healthy Families, Healthy Kids, and local community clinics. We urge religious organizations to reach out to the uninsured and to facilitate their enrollment in these existing programs;

b. Participate in established public health outreach and "parish nurse" programs that

offer congregation-based health care education, screening, inoculations, and other preventive health care services;

c. Create programs through which volunteers provide transportation and other forms of support for persons who face barriers in accessing the health services they need;

d. Conduct health fairs offering medical screening for the uninsured;

e. Support workers seeking to secure healthcare for themselves and their families.

Health care is everyone's problem. It is everyone's sacred obligation. There is something everyone can do to contribute to the solution. This is our call!

The Los Angeles Council of Religious Leaders

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Health Care Task Force

Los Angeles Council of Religious Leaders

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