Christian Ethics and Health Care Reform

Tackling the tough problem of health care reform in America is not a popular topic for a sermon or small group discussion. The complexity of the current situation, magnitude of the problem, and proposed solutions are enough to scare many people away from considering the topic at all. Yet talk about it we must, for two main reasons. First, it is a growing problem, seen in the increasing number of uninsured people and in the ballooning health care premiums. Second, as Christians who believe in the Lordship of God over all areas of our lives and who are called to care for the “least of these” in our society it is imperative that we examine the issue in light of Scripture. To achieve these ends this paper will look at the current situation of health care in America, proposed reforms to the system, and conclude with some thoughts on how Scripture can guide us in this area.

Health Care in America Today

“Lack of health insurance coverage is a problem for many more Americans than it was 10 years ago.”1 Nearly 45 million Americans under the age of 65 were uninsured in 2003, which is an increase of 5 million since 2000. Although there has been a slight decrease in the number of uninsured children since 2000, due to Medicaid and State Children's Health Insure Program (S-CHIP) increasing their coverage, a quarter of the children in America lack health coverage.2 While Medicare covers virtually all those who are 65 and older, and Medicaid and S-CHIP covers many poor families, there still exists a

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2 Ibid., 11.
large gap of 18% of the population under age 65 who are uninsured. Some myths about those in that gap should be addressed, before continuing.

*The majority of the uninsured are idle and do not work.* In fact, just the opposite is true: “8 in 10 uninsured came from working families – 70% from families with one or more full-time workers and 12% from families with part-time workers.”³ Furthermore, most uninsured workers were not offered employer-sponsored insurance – 64% of uninsured workers were not offered health insurance.⁴

*Lack of insurance equally affects the rich and poor.* Actually, because of the high cost of health care, the poor are at a far higher risk of being uninsured. Two-thirds of uninsured are low-income people or from low-income families. Because Medicaid does not provide coverage to all disabled and low-income individuals, because small businesses and service-sector jobs are less likely to provide coverage plans, and because private policies are so expensive there are a large number of low-wage workers who do not have health care.⁵

*The uninsured can just go to the emergency room for health needs.* While studies do show that the uninsured end up using the emergency room for some of their health care needs, this does not mean they are receiving adequate health care. The incredible costs of some acute and long-term services have the ability to move a family from the status of low-income to impoverished in one fell swoop. Additionally, because of the costs, many of the uninsured forgo preventative care and do not follow up on recommended treatments and prescriptions. Even when they are hospitalized they are more likely to receive fewer services and to die in the hospital than insured patients. In

³ Kaiser, 4.
⁴ Ibid., 13.
⁵ Ibid., 4, 13.
fact, their mortality rate for a given procedure is 1.8 times higher than an insured patient.\textsuperscript{6}

\textit{The uninsured receive health services for free or at a reduced charge.} In actuality, the uninsured are increasingly being made to pay “up front” before they can receive care. Furthermore, only rarely do the uninsured receive services at a reduced rate, and in fact they may be charged higher fees than those negotiated by health insurance providers.\textsuperscript{7}

\textit{The health care problem is driven by immigrants who are not American citizens.} The large majority of the uninsured (79\%) are American citizens. While nearly half of all non-citizens are uninsured, they are not primarily responsible for the increase in the number of the uninsured, primarily because their numbers are comparatively small.\textsuperscript{8}

America faces a crisis of access and a crisis of costs in health care. The crisis in access is seen in the vast number of Americans living without insurance. Additionally, those who must use Medicaid are frequently receiving “second class” care. The crisis of cost is evident in the fact that America spends 15\% of our gross national product on health care, and this number continues to grow. The consequences of these spiraling costs threaten to close small businesses that insure their employees and bankrupt government programs.\textsuperscript{9} These crises have driven most to agree that America's health care system is in need of dire reform.\textsuperscript{10} Just what sort of reform is a far more contested issue.

\textbf{Proposals for Reforming Health Care}

Before looking at specific ideas for reforming health care we must look at why

\begin{itemize}
\item[\textsuperscript{7}] Ibid., 9.
\item[\textsuperscript{8}] Ibid., 5.
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health care costs are rising so rapidly. An oft-cited reason is that waste, fraud, and overuse are the primary factors driving up health costs. While those are all factors in the equation, there are several other factors which create far more of an impact. One factor is that Americans are living longer which means we are receiving more care than ever before. Second, state regulation has gradually required health insurance companies to expand their range of mandatory coverage to include such things as health and drug treatment, mental-health therapies, and preventative screenings like mammograms. However, the most important force is new technology. These technologies help people live longer, cure debilitating diseases, and provide treatments for life-threatening conditions such as heart attacks, cancer, and AIDS, but they all cost money. It is true that many of these technologies are getting cheaper and more effective, but this also means they are being more widely used. This sudden rise in new technologies is no accident; federal funding for new health research is one of the the few domestic programs to continue to grow, with the current budget allocating almost $29 billion to it.\(^\text{11}\)

One response to the above analysis is to focus on better management of terminally ill patients. It is true that caring for seriously ill patients account for the majority of health care costs. Furthermore, we should certainly clarify the laws surrounding end-of-life issues so that we know who, and in what circumstances, someone can say “enough.” However, most seriously ill patients don't die and we often cannot know with any certainty which ones will die. Thus, this answer is too simple a solution for such a complex problem.\(^\text{12}\)

Another overly simple solution, alluded to above, is that we only need to get rid of

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\(^\text{11}\) Charles R. Morris, 13-16.
\(^\text{12}\) Ibid., 15.
waste and abuse of medical resources. Certainly we should crack down on abuse and weed out unethical doctors and health care providers who are using the system to profit themselves. Conservatives are right to insist that there must be a clearer delineation between essential and elective treatments and that requiring up-front costs from all patients has the potential to prevent the problem of patients trying anything as long as it's covered. However, even if we get rid of every greedy vendor and unnecessary drug, we will only shave off a few percentage points from the total cost of health care. Indeed, to try and solve the problem in this way is to deny our inherent limitations. We must face the fact that our health care system will never be able to provide everything to everyone.

That there are inherent limitations to any health care system should not dissuade us from reforming (or replacing) the current one. Nor are the increasing costs as prohibitive as we might assume. While, we are spending far more on health care than fifty years ago, we are still only spending half our income on necessities. The is because the cost of some necessitities, such as clothing and food, has significantly decreased. Furthermore, health care is a very good place to invest money. Not only does it make workers more healthy and productive, but it also generates a large amount of industry and jobs which cannot be exported overseas.

Given the complexity of the issue, there is an abundance of specific reform proposals. However, most involve a combination of strategies to improve health care gradually. One proposal is to work within the confines of the current system by building upon Medicaid and S-CHIP to expand public coverage to the low-income uninsured. If Medicaid is made available to more non-elderly low-income adults it has the potential to

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13 Ibid., 15.
14 Ibid., 16.
reach two thirds of the uninsured population. However, some worry that Medicare/Medicaid will quickly run into debt given the surge of baby boomers who will be turning 65 shortly, especially since the Medicare Trustees project estimates that the trust fund's savings will run out by 2019.

Another strategy is to expand employer-provided coverage. Currently most Americans receive their coverage from their employers, and 80% of the uninsured are working themselves or have a connection to the workforce. Proposals range from mandating employers to provide health insurance to providing financial incentives for employers who provide health insurance to allowing small employers and the self-employed buy into larger insurance purchasing pools. Many worry, however, that with the ever-increasing “basic” package of health benefits, small employers will simply not be able to afford it. Furthermore, workers are changing jobs far more frequently than they did fifty years ago, which means they are left without any coverage during the period between jobs.

In response to the problem of increased job-shifting some propose making private individual health insurance more affordable with tax credits or deductions. However, the success of such a plan depends on how well health insurance agencies can adapt to patients with high health needs, such as those with chronic diseases who would likely be excluded from non-group policies today. This means that the cost to the government could be quite high, even if only the low-income are offered subsidized health care.

A final strategy is to create a universal health care system that provides coverage

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15 Kaiser, 16.
16 Charles R. Morris, 12.
17 Ibid., 17.
18 Kaiser, 17.
to everyone. The Clintons proposed such a plan in 1994 with the Health Security Act which would have provided a “comprehensive benefit package” to everyone in the same geographic region. His proposal sparked a flurry of debate. What treatments are medically “necessary and appropriate”? Should taxpayers be forced to fund a system they find morally objectionable (in this case, many Christians opposed the fact that abortion would become a federal entitlement)? Should the fitness fanatic and the smoker both receive the same amount of treatment? Would the government be increasingly in charge of deciding when to end life-sustaining treatment because a patient exceeded their expense quota? Would managing such a complex system become a mess of bureaucracy and wasted money?

Biblical Considerations

Having looked at the state of health care in America today and the proposed strategies to remedy the problem we are now ready to look at how Scripture should inform our view of the issue. In medical ethics, no Biblical story is as oft told as the story of the Good Samaritan. Along the road to Jericho a man lay half dead, having been robbed, beaten, and left for dead by a band of robbers. It was not the priest or Levite who had compassion on him, but a Samaritan. Moved to pity he kneeled beside the wounded man and dressed his wounds with oil and wine. The Samaritan then put the man on his donkey, and brought him to an inn. Not only did he pay two day's wages for the man's stay, but he also promised the innkeeper that he would repay any and all additional costs when he returned (Luke 10:25-37). It is a good story; a story that drives us to compassion and challenges our narrow definition of what it means to be a neighbor.

20 It is also a story which corrects any notion that we need not worry about developing public policy which does not affect “us” (i.e. Christians). The Christian Coalition, for example, opposed the Clinton plan in
When we translate the story to medical ethics, however, a problem arises: scarcity. What would the story have looked like if there had been ten wounded men? What if wounded men along the road to Jericho was a persistent problem? What if the wounded man's care cost more than the Good Samaritan could afford? Suddenly, the Good Samaritan, whose unlimited compassion is so compelling in the story, becomes a tragic figure who must choose between goods. Thus, if we are to have this story inform our vision of health care we must find how it fits in the story of scarcity.

A first step then, in evaluating any health care plan, will be to ask if it acknowledges scarcity. Often the story of medicine and health care is told as the story of a limitless frontier. Doctors are seen as waging battles against sickness and death on the edge of a frontier. While they are sure to lose some of the battles, they nonetheless march steadily on into an endless horizon of possibilities. Yet, the story of Scripture reminds us of our human mortality, that Christ, not medicine, is our savior, and that resources are finite, for the Kingdom of God has not yet come in full. A story of limitless frontiers will not make us people who are content with our limits or who are truthful about the fact that our finitude ensures that we will have to make tragic choices in the area of health care; choices where real goods collide.

Sanctity is the good that is sure to collide with any acknowledgment of our limits. The Samaritan saw a neighbor in need, and he felt the pain in his own being. He was moved by compassion to care. It didn't matter that the wounded man was an enemy of his people. It didn't matter that he worshipped in the wrong place or the wrong way.... What mattered was the hurt, the

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1994 because, in part, it provided coverage for substance-abuse treatment and mental-health care because churchgoing families are less prone to use such services (John W. Kennedy, 2). Such an approach belies Jesus' point in the story of the Good Samaritan: we are not called to decide who is and is not our neighbor, rather we are called to be the sort of people who are neighbors to those in need.

21 Allen Verhey, “The Good Samaritan and Scarce Medical Resources,” Reading the Bible in the Strange World of Medicine (Grand Rapids: Eerdmans, 2003), 359.

22 Ibid., 361.

pain, the need of one who was, after all, like him, the object of God's unbounded love. And that unbounded love conferred upon the wounded man a sanctity that in turn evoked the limitless care of the Samaritan. 24

This acknowledgment of the dignity of all persons, of the fact that they bear the image of God, is what drives us to acknowledge that every person has a right to life, and thus a right to the means “necessary and suitable for the development of life.” 25

Scarcity of health care resources, our desire to care for others because of their sanctity, and our calling to live into the story of the Good Samaritan means we must give some attention to public policy, even if the story cannot tell us the particular policy we should adopt. Yet, the tension inherent in these principles means that compassion, exemplified in the Good Samaritan, does not provide us enough guidance for deciding how we to limit and allocate scarce resources. For this task we must also be guided by the principle of justice. In our society, the notion of justice is primarily shaped by liberal democracy where justice is a set of boundaries and entitlements given to each individual. Liberal democracy seeks to give each person “maximum freedom,” as long as that freedom does not infringe on another's freedom, and “presumptive equality,” where inequality is considered unjust unless it provides significant benefits for those who are least well off. In this sense, I am being just so long as I do not infringe on your boundaries. Noticeably, this notion of justice provides no positive reason why I should aid others if doing so does not benefit me. However, we who have heard Jesus' proclamation that he is a preacher of “good news to the poor” (Luke 4:18), who have been formed by the story of the rich man and Lazarus (Luke 16:19-31), and who long to form a community where “there was not a needy person among them” (Acts 4:34) will

not be content with the liberal democratic notion of justice. Justice, when formed by Scripture, is the good news of care for the poor and empowerment for the marginalized.26

These Scriptural principles of compassion and justice push us towards a commitment to a public policy that provides health care for all. We might object, however, that providing universal health care only leads to bureaucracy and misuse; far better to let the invisible hand of the market create an efficient system for all. Yet, to treat health care as a commodity, like we do trucks and t-shirts, has two shortcomings. Firstly, the free market has no obligation to help the “least of these.” In the free market, if you cannot pay for a good then you don't get it. This works fine when we are discussing things that are not necessary to protect life, but it does not work when we are discussing health care.27 In this sense, health care is analogous to police protection, where it would be unjust to make people pay for a decent standard of security. Secondly, if we treat health care as a commodity we neglect the fact that it serves to provide a decent standard of life and health. This is similar to our commitment to providing public education which also provides a certain range of opportunities that we believe all should have.28

Another objection that might be raised against universal health care is whether the criminal, the chronically unemployed, or the non-citizen also deserve of even minimum health care that is paid for by public monies? Yes, for to begin making distinctions on who has a right to life and who does not is an affront to the inherent dignity of each person, each of which bears the image of God.29 To take such a view is to deny that all

29 O'Rourke, 262
who hurt are the objects of God's boundless love, whatever their social worth or promise.\(^\text{30}\) Furthermore, it denies that, even as a nation, we are a community of interdependent people. In providing health care to all members of our society we say “We will care for you; we will not pass by your suffering.”\(^\text{31}\)

Attention to the Scriptural themes of compassion, justice, and sanctity, while not denying the tragic reality that scarcity exists, pushes us to providing a “decent minimum” of health care to all. Yet, what do we mean by a “decent minimum”? It certainly does not mean it will include everything medicine can provide, for that would be to deny scarcity. Because medicine protects against threats on our life and health it would provide immunizations and proven preventative surgeries. Furthermore, since medicine provides a certain range of opportunities, a “decent minimum” will include medical and rehabilitative treatments that “restore or maintain functioning..., as appropriate for age and condition.”\(^\text{32}\)

We might rightly wonder, though, how scarce medical resources will be provided in such a system when there are not enough for everybody (i.e. organ transplants). Who should be a candidate for a scarce resource should be based on medical criteria that judges who is most likely to survive and benefit from the resource. This means we will not choose candidates based on their social worth or promise, such as whether they are “smart” or “productive,” for to do so would be to deny their sanctity. The next step, picking an actual candidate to receive the resource, would best be done by picking them randomly. Random selection is not arbitrary or irrational, rather “it is the rational refusal


\(^{31}\) Ibid., 384.

\(^{32}\) Ibid., 385.
to deny either scarcity or sanctity.”

Of course, providing such a “decent minimum” standard of health care means that the market will be allowed to regulate care above and beyond the “decent minimum.” Such a “two-tier” system is unjust, only that, within the constraints of scarcity, we cannot provide the best health care for everyone, as much as we desire to do so.

The issue of health care in America raises many good questions about how Biblical ethics are worked out in the realm of public policy, what our obligation is to those outside the faith community, how we are to deal with a fallen world in which scarcity is a reality, and what it means to be a Good Samaritan whose compassion is costly. This paper is not meant to be a definitive pronouncement on what the church’s position on public health care should be, rather it is meant to be a starting point for further discussion and reflection. And more discussion is needed, for many questions remain unresolved such as “How does our standard of care change based on age and condition?” and “In what ways can a health care system for all also prevent misuse and overuse, especially in a culture which is often desperate to ward off sickness and death at all costs?” The hope of this paper is that it will aid the church in continuing to faithfully live out a long history of caring for the sick and dying.

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33 Ibid., 391.
Bibliography


