

Using Caring for Health: Our Shared Endeavor

In Your Congregation



A Study Guide Prepared by
The Division for Congregational Ministries
and The Division for Church in Society
of the Evangelical Lutheran Church in America

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Introduction

What is *Caring for Health: Our Shared Endeavor* and Why is It Important to Study?

Social Context. During the past few decades health care in the United States has been in crisis. Many see the general health of the American people in trouble. The costs of health care have soared. The care people receive and that insurers pay for is more expensive every year. At the same time, the number of people without health insurance has also soared dramatically; in 2003, well over 43 million individuals had no insurance to help pay for the care they needed. Meanwhile, various measures suggested that Americans were generally not taking good care of their health in areas such as lifestyles, diet, etc. that are at least partially under their control.

The Church and Health. The church has always had a concern for healing. For generations, Lutherans in the United States have been leaders in health care. They have developed hundreds of social ministry organizations (including hospital systems) to address both physical and mental health. They also are developing a growing number of congregational health ministries. In the 1990s, the ELCA participated in an ecumenical effort to address the lack of health insurance for a growing number of Americans that coincided with congressional consideration of several legislative initiatives to address health care.

How Did This Statement Come into Being?

A new social statement on health and health care was authorized at the 1999 Churchwide Assembly. Shortly after that the ELCA Task Force on Health and Health Care was appointed by the Board of the ELCA Division for Church in Society. As part of its work the task force held listening posts throughout the ELCA in 1999 and 2000. In 2001 a study booklet, *Our Ministry of Healing*, was published and distributed to all ELCA congregations along with a request for comments to be sent to the task force. In 2002 a first draft of the statement was published and comments were solicited and received from many individuals, organizations,

and churchwide units. In 2003 the final draft of the statement was presented to the Churchwide Assembly in Milwaukee, Wisconsin. It received overwhelming support and was passed by a vote of 935-34.

The twenty individuals and churchwide staff who comprised the ELCA Task Force on Health and Health Care spent nearly four years studying, researching, discussing, sharing, and ultimately writing the document that became *Caring for Health: Our Shared Endeavor*. The task force included people with a wide range of experience: doctors in family medicine and oncology, a hospital administrator, a pastoral theologian, a biblical scholar, someone with a family member living with mental illness, a medical ethicist, a parish pastor, a synod bishop, leaders in congregational health ministry, a co-owner of a rural pharmacy with experience in county government, someone with experience in public health, a business school professor with expertise in health insurance, the CEO of a rehabilitation facility, a pastor with chaplaincy experience, and a leader in Lutheran social ministry. The notion of “shared endeavor” emerged near the end of the process as a key understanding of how health and wholeness are achieved and maintained for us all. It is not something we do alone.

Using Social Statements in Congregations. ELCA social statements come to life as they are studied and acted on by members of ELCA congregations. “Social statements are meant to foster the art of ethical reflection and discussion in congregations and other expressions of this church. They depend on a vision of the Church as a community of moral deliberation in which serious communications on matters of society and faith is vital to its being. United by baptism, members are free to discuss and disagree, knowing that they are ultimately bound together in the body of Christ by the Gospel and not by their moral judgments.” (ELCA “Guiding Perspectives for Social Statements” [c. 2000], p. 2. See also the other excerpts from this publication about the purpose of ELCA social statements elsewhere in this study.)

The central message of the social statement, *Caring for Health: Our Shared Endeavor*, is expressed in the opening paragraph:

- “As a personal and social responsibility, health care is a shared endeavor”
- The statement goes on to call the Church and its individual members to respond to this shared responsibility: “The Christian Church is called to be an active participant in fashioning a just and effective health care system. Responding to those who were sick was integral to the life and ministry of Jesus and has been a

central aspect of the Church's mission throughout its history. Health care and healing are concrete manifestations of God's ongoing care for and redemption of all creation. We of the Evangelical Lutheran Church in America have an enduring commitment to work for and support health care for all people as a shared endeavor."

- Regarding our individual responsibility for our personal health, the statement says, "Each of us has responsibility to be a good steward of his or her own health out of thankfulness for the gift of life and in order to serve God and the neighbor."

The statement proceeds in the following way:

- Begins theologically with the importance of health, illness, healing, and health care in light of God's work of creating, redeeming, and sustaining humanity.
- Presents a vision of health care in light of these biblical and theological insights that includes our personal responsibilities as well as the church's ministry in congregations, social ministry organizations, and advocacy. That vision also aims at a better system of health care services in society than we now have, and describes what the basic features of such a system should be.
- Addresses the issue of equitable access to health care for all in our society as a matter of public and private policy.
- Outlines the ethical criteria for individuals and families as they make difficult decisions regarding the care of loved ones for whom they are responsible.
- Concludes with a series of implementing resolutions.

Purposes of the Statement. All who undertake this study need to be familiar with the purposes of the social statement. As an ELCA social statement, *Caring for Health: Our Shared Endeavor* offers theological and ethical perspectives to equip the ELCA and its members to fulfill their calling to serve God in the world with respect to health and health care. It is intended to guide staff, pastors and other professional leaders, teachers and other lay persons in their response to issues of health and health care personally as well as in church, community, society, and world. (See also the excerpts from "Guiding Perspectives for Social Statements" on page 31 of this guide.)

The concern of this statement is our calling to fulfill our responsibilities not only for our own health, but also for the health of our neighbor in family, church, community, society, and the larger world. You may wish to consult other resources that will complement this concern:

- **Global Health.** Although its focus is largely the United States, its territories, and Puerto Rico, you may also want to consult the Division for Global Mission's Policy Statement on Health Ministry and its related background material listed in the resources later in this guide.
- **Community Violence.** You are also encouraged to consult the ELCA's "A Message on Community Violence," for additional insights about threats to health in our communities from violence.
- **Scripture.** While the social statement is not a comprehensive Bible study on healing and health, it cites Scripture in certain places. This guide, however, does offer occasions for biblical reflection on certain passages. Other Bible study resources on healing and health may also be consulted.

Helps for the Leader: Planning and Leading a Study of *Caring for Health: Our Shared Endeavor*

What is in this Guide?

This study guide provides:

- At plan and instructions to facilitate a study of the Evangelical Lutheran Church in America's social statement, *Caring for Health: Our Shared Endeavor*.
- Content sheets at the end of this guide that may be photocopied and distributed to participants in the study.
- Suggestions to help adapt the model to various circumstances or settings. The basic study in this guide is designed for five one-hour sessions.

The study process in this guide is designed to help participants understand the statement, to explore, reflect upon, and discuss its implications for themselves and their congregation, and to invite them and their congregation to action.

Leaders and participants will need a copy of this guide and a copy of *Caring for Health: Our Shared Endeavor*. The ELCA grants permission to copy the social statement for congregational study, providing each copy displays the copyright notice found on the back page of the booklet. Or, you may order copies by calling Augsburg Fortress at 800-328-4648 and asking for item number 6-0001-7736-4. Helpful background about why the ELCA issues social statements and what they are for is found in “Guiding Perspectives for Social Statements.” Ask for item number 6-0001-3196-8.

Aims for the Study.

Through this study, participants will:

1. Become acquainted with the contents of the ELCA social statement, *Caring for Health: Our Shared Endeavor*;
2. Deepen their awareness of the biblical and theological basis for their calling to care for the health of both themselves and others in society;
3. Explore the implications of this calling for their lives as people of faith and as citizens, as well as its implications for the church;
4. Increase their understanding of the many aspects of caring for health as a shared endeavor.

Settings for the Study

This study might be used in:

- a series of adult classes;
- a one-day workshop, combining the five sessions into four time blocks divided by coffee and lunch breaks;
- an overnight retreat, organized in a similar manner;

- two sessions of about three hours each on Saturday or an evening during the week.

You will want to adjust the study and participant preparation so that it will fit the setting you choose.

The study is designed to be used in mixed groups that include men and women of various ages. If you lead a study with a particular group, such as women or youth, tailor the study to your participants.

Laying the Groundwork

1. Order or assemble the materials you will need to lead the study, including copies of this study guide, copies of the social statement, and other materials you think would enhance the study. Multiple copies of ELCA materials may be ordered from Augsburg Fortress at 800-328-4648. You may want to give copies of the statement and this guide to participants before your study sessions.
2. Suggest that all participants read the social statement, *Caring for Health: Our Shared Endeavor*, carefully in preparation for your study. If you distribute copies of this guide before your class session, ask participants to read the guide, particularly the introduction and “Guideposts to Learning” page 12. Change and adapt the sessions in this guide as may be appropriate for your particular audience and setting.
3. Work closely with those responsible for education in your congregation so that this study will fit with its overall education plan.
4. Decide on the group for which the study will be intended, the setting for the study, and how long the study will be.
5. Develop a plan to publicize the study in your congregation for recruiting participants. Be aware of particular groups of people who may be interested in it, such as those who work or volunteer in health care, public health, community violence, patient advocacy, and so on.
6. This guide includes suggestions for brief opening and closing devotions. Some study participants may be willing to prepare and lead more extensive group devotions.
7. If possible, arrange seating so that participants can face one another.

8. Each session notes what materials or arrangements will be needed. An easel pad with newsprint or a chalkboard or whiteboard will be helpful.

Tips for Effective Discussion Leadership

You may want to share the leadership of your discussion group. Those who take a leadership role will find the following helpful as they prepare:

1. Be prepared

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

2. Set a relaxed and open tone

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

3. Establish clear guidelines for the discussion

At the beginning of the session, establish the guidelines and ask participants if they agree to them or want to add anything:

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

4. Stay aware of and assist the group process.

- Always use your “third-eye;” you are not only helping to keep the group focused on the content of the discussion, but you will be monitoring how well the participants are communicating with each other – who has spoke, who hasn’t spoken, and whose points haven’t yet received a fair hearing.
- Consider splitting up into smaller groups to examine a variety of viewpoints or to give people a chance to talk more easily about their personal connection to the issue.
- When wrestling with when to intervene, err on the side of non-intervention.
- Don’t talk after each comment or answer every question; allow participants to respond directly to each other. The most effective leaders often say little, but reflect on how to move the group toward its goals.
- Don’t be afraid of silence. It sometimes takes a while for someone to offer an answer to a question you pose.
- Don’t let anyone dominate; try to involve everyone.
- Remember: a forum is not a debate but a group dialogue. If participants forget this, don’t hesitate to ask the group to help re-establish the guidelines.

5. Help the group grapple with content.

Make sure the group considers a wide range of views. Ask the group to think about the advantages and disadvantages of different ways of looking at an issue or solving a problem. In this way, the trade-offs involved in making tough choices become apparent.

- Ask participants to think about the concerns and values that underlie their beliefs.
- Don’t allow the group to focus on or be overly influenced by one particular personal experience or anecdote.
- Either summarize the discussion occasionally or encourage group members to do so.
- Remain neutral about content and be cautious about expressing your own values.

- Help participants to identify “common ground” but don’t try to force consensus.

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

Some useful discussion questions:

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

7. Reserve adequate time for closing the discussion.

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

Discussion Guidelines

- Share your concerns and beliefs
- Listen carefully to others
- Be willing to examine your own beliefs in light of what others say
- Speak your mind freely, but strive to maintain an open mind
- Strive to understand the values and ideas of those who see things differently from you
- Cooperate with the leaders to keep the discussion on track
- Be sure that everyone has equal time to share their ideas

- Address remarks to the group and not an individual
- Communicate your needs to the leaders
- Value your own experience and opinions
- It is OK to disagree
- Humor and a pleasant manner can go far in helping you make your points. They help everyone to remember that disagreement is not personal. When we disagree in this dialogue, we disagree about values or ideas, not about individuals or personalities.

From: "A Guide to Training Study Circle Facilitators"

(Reprinted with permission from the Study Circles Resource Center (SCRC), a national organization that helps communities engage all kinds of people in dialogue and problem solving on critical social and political issues. Please visit www.studyircles.org for more information.)

Guideposts to Learning

- Encourage a spirit of enquiry and deliberation: If all the issues raised in this study were settled, we wouldn't need the social statement or the study. By having the study, congregational members can enquire and learn together. We can deliberate about what these issues mean for the faith and the ministry we share.

A spirit of enquiry, listening, learning, and deliberation is appropriate for Lutherans. The Lutheran church grew out of a movement that began in a university and engaged serious questions about Christian faith and practice.

Because many issues about health and health care are not settled, and because people have different views about those issues, it is important that we listen to others. We are more likely to give others a respectful hearing and to learn from them when we listen to them respectfully.

Some of the issues in this study involve questions of right and wrong, good and bad, just and unjust. These questions invite us to deliberate about how they should be resolved. We may not always agree. But we can engage in honest and mature discussion about how the church should respond to these questions. This deliberation also can be an occasion for discerning how God may be active in the midst of these complex questions.

- Engage our Christian biblical and theological heritage: The Bible is the Word of God and the source and norm of the church's life and faith. A concern with health and healing was integral to the life and ministry of Jesus, who is our touchstone for interpreting the scriptures. The social statement has a robust theological discussion of health, healing, illness and health care, and this study guide invites us to reflect on how scripture informs our understanding of health and health care, as well as our understanding of ministry of the whole church and of our congregation. Engaging our biblical and theological heritage helps us to discern how God is active in these issues, and what God may want us to know, believe, and do about them.
- Draw upon the personal experiences: Personal and social experience are often the most concrete way we can begin to engage issues such as those raised in this study. Those experiences help to enrich the study by giving life and detail to issues that may sometimes seem abstract or remote. They also may help us discern what God is up to today in health, healing, and health care. Experiences allow us to include the wealth of personal involvement in these issues and to relate them to the experience of our communities and our society.
- Feelings can be signposts to new learning: Feelings tell us what is meaningful and important. Our feelings disclose both joy and pain. Feelings can alert us to important things that need attention. When, as the church, we attend to feelings, we show we are able to deal with each other's real lives and the real world we all live in every day. Feelings need to be acknowledged. Take time to put your feelings into words. Reflect on your feelings. And, when possible, seek to discern insights from your feelings that can help the study. Avoid judging words and actions that reveal others' feelings. Give feedback that lets others know what feelings you heard them express so they will know how they are being heard.

Session One

Health as an Issue of Faith

Social statements...inform, guide, and challenge this church and its members. They are intended 'for the equipment of the saints, for the work of ministry, for building up the body of Christ.' (Ephesians 4:12)

Session Objectives

In this session we want to:

- Become familiar with the social statement and the study series.
- Discuss the guiding principles for social statements in the life of the church.
- Reflect on the biblical and theological principles on which this social statement is based.

In Preparation

- Read through all session materials
- Obtain needed materials
- Check room setup to comfortably accommodate expected number of participants

Materials Needed

- Copies of the Social Statement and of this guide for each participant
- Bibles for each participant or copies of John 15:12-17
- Hymnals or copies of, if you choose, a hymn for each participant

Session Plan

Opening:

Open with prayer (Psalm 130 and Psalm 88 are prayers for healing and restoration) and/or a hymn like “Healer of Our Every Ill” (*WOV #738*) or “My Hope Is Built on Nothing Less” (*LBW #294*).

Getting Started

- Introduce yourselves and share what motivated you to be a part of this study process.
- Read over or summarize the “Introduction” in this guide (pages 3-12). Discuss any questions or concerns that arise and talk about what you hope to accomplish by this study.
- Look together at Content Sheet 1 “Guiding Perspectives for Social Statements” on page 31 of this guide. Take turns reading the six descriptive statements out loud and then share any comments or reflections on the perspectives.

Study and Discussion

1. If you have not done so, distribute copies of the social statement. Read over or summarize pages 3–7 of the statement – “Biblical and Theological Perspectives.” Mark any statements or ideas that you find particularly interesting or that raise questions for you.
2. Divide into small groups of three to four people. Share your reactions to what you have read. Then, discuss the following questions:
 - *What theological or biblical perspectives in the statement did you find interesting? What questions, if any, did these raise for you?*
 - *What or who helps you personally to maintain good health?*
 - *Everyone experiences times of anguish such as those described in Psalm 88. If you are comfortable in doing so, share a story of a difficult time from your personal experience or that of someone close to you. What helped you/them to get through this time?*

Return to large group. Share any highlights or insights from your conversations that you feel were significant for you.

2. Read aloud John 15:12-17. Then read the description of health care on Page 6 of the social statement. *What are the connecting points between the biblical text and the description?*

Between Sessions:

- Take some time to read or reread the social statement and this guide.
- Interview one or more of those you know who are in “good health.” What do they do to maintain their health? What can we learn from them? Share your discoveries with the class.
- Ask a number of people for their definition of health. Note their responses and bring them to share with the class.

Closing:

“A Prayer for Health, Healing and Health Care.”

L.: Lord our God, we are in need of your healing. Our minds and bodies are afflicted. You said to Israel, “I am your healer,” and Israel was restored.

C: Renew us now, and make us whole in mind and body, heart and soul.

L: O Christ, your earthly ministry touched the lives of people in their entirety. You healed the sick. You raised the dead. We give thanks for all agencies that provide health care. We pray for Lutheran social ministry organizations that carry on your healing ministry in our day.

C: Raise us, dear Jesus Christ, we pray, to life and health, for work and play.

L: Spirit of life, you give us faith and wisdom to trust you and love others. Help us to care for our bodies and minds. We give thanks for people whose calling in life is to assist those in need of healing or health care. Strengthen for service all medical professionals.

C: Encourage those who healing bring, that we, with them, your praise might sing.

L: Triune God, you suffer with all who long for health but cannot afford care, and you call for justice. Grant that our society may create a just system of health care so that all your children may rejoice in your healing.

C: Praise God in whose strong arms we dwell,

Praise God in Christ, who makes us well,

Praise Holy Spirit, healing Dove,

O God of hope, O God of love.

From "Introducing Caring for Health: Our Shared Endeavor" Copyright © 2004
Evangelical Lutheran Church in America; based on a hymn by Dr. Fred Gaiser, Luther Seminary,
titled "I Am Your Healer" (©1999).

Session Two

What is Health?

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

[“Caring for Health: Our Shared Endeavor” page 1]

Session Objectives

In this session we want to:

- Discuss the impact of the crisis in health care on each of our lives.
- Establish a working definition of health and health care for this study and beyond.
- Begin to examine the idea of health and health care as a shared endeavor.

In Preparation

- Read through all session materials
- Hang up two large sheets of paper to write on or clear space on white board/easel
- Check room setup to comfortably accommodate expected number of participants

Materials Needed

- Paper and pens/pencils for participants to make notes during small group discussion
- Bibles for each participant or copies of Luke 10:29-37
- Hymnals for each participant as necessary

Session Plan

Opening:

Welcome everyone. Begin with prayer. A Psalm or the prayer used to close the last session would be appropriate.

Getting Started

- Sharing: What happened this week or what assignments did you carry through on from the last session that caused you to recall or reflect on last session's learnings? Share some of these.
- Introduce yourselves and share the answer to the question: "What role do you play in the current health care system? consumer, nurse, insurance broker, employer, physician, family caregiver, etc.?" A volunteer might list roles on a large sheet of paper or white board.

Study and Discussion

1. Take turns reading out loud paragraphs 1-5 "The Crisis in Health Care" on pages 1-2 of the social statement. How does the current crisis impact your daily life? As you discuss, a volunteer might list areas of concern on large sheet of paper or white board.
2. Look at Content Sheet 2: "Some Definitions of Health." In groups of two to three read definitions and share your understanding of the definitions. Talk about your questions or insights:
 - *What appeals to you?*
 - *What is missing?*

3. Look at Content Sheet 3: “What is Health?” In same small groups, take turns reading the definitions and then share reactions with each other.
4. Read Luke 10:29-37. *Where do you see the descriptions of health reflected in this parable? In the parable, who was “healthy”? What does it mean to us to “go and do likewise”?*

Between Sessions

- Read or reread pages 21 –22 of the social statement “Ethical Guidance for Individuals and Families.”
- Find out what you can about Lutheran social ministry organizations (SMO’s) in your area. Share your discoveries with the class.
- Begin a “health journal.” Write in the journal each day some of the following: insights on health care; those who are in need of prayer because of health issues; discoveries about health and healing; actions you take to improve your own physical, spiritual, or mental health.

Closing:

Close with a hymn like “Go My Children, with My Blessing” (WOV # 721), or another hymn, song, or prayer.

Session Three

A Shared Endeavor

“We offer a vision of health care as a shared endeavor that builds upon the basic dimensions of health, illness, healing and health care in relation to the interdependent responsibilities that must be addressed if progress toward better health care is to be achieved.

[“Caring for Health: Our Shared Endeavor” page 7]

Session Objectives:

In this session we want to:

- Reflect on the purposes of health.
- Come to understand the variety of shared responsibilities that affect health care in all of its dimensions.
- Identify ways congregations can support health for individuals, families, and communities.

In Preparation

- Read through all session materials
- Make copies
- Check room setup to comfortably accommodate expected number of participants

Materials Needed

- Paper and pens/pencils for participants to make notes during small group discussion

- Bibles for each participant or copies of 1 Corinthians 12:4-11
- Hymnals for each participant if using

Session Plan

Opening:

Open with prayer, a Psalm or hymn.

Getting Started

- Welcome all. Have new participants introduce themselves.
- Review: *What do you recall from the last session that was particularly meaningful or helpful to you?* Share some of these thoughts and some of your continuing concerns.
- Reflect on your reading assignment or the other activities you did during the week. *What was helpful? What did you learn? What surprised you or offered you a new perspective?* Share some of these.
- Discussion: *What is health for?* Talk about your understandings as you read through the following: Some purposes of health:
 - To enable us to participate as fully as possible in common life with others in families, communities, places of work, congregations, political life, as our capacities and conditions allow, and on our own terms;
 - To remain faithful to our calling from God in community with our neighbor; and
 - To live lives of prayer, praise, thanksgiving, and service to God and one another.

What other purposes would you add? Does your current state of health fit with these purposes?

Study and Discussion

1. In groups of two or three take turns reading out loud pages 7 and 8 of the social statement “Personal Responsibilities.” Discuss what you have read using the following questions:

- What would you need to do to become an effective steward of your personal health?
- What does it mean “to demand unlimited resources for services that go beyond responsible stewardship of good health”?
- If you have had conversations with your family members about end-of-life care, what suggestions would you offer to someone who has not been able to do this?
- What are some examples of what your congregation does to support those who are ill and/or their caregivers?

Share one or two insights from your conversations that you found particularly helpful.

2. Read Pages 9-10 of the social statement “The Church’s Ministry” and “Congregations.” In groups of two to three reflect on the various ministries of health and healing that congregations can provide.
 - Make a list of those which are currently a part of your congregation’s ministry.
 - What other healing ministry takes place in your congregation, even if it is not named as such?
 - What else could we be doing that we are not doing?
 - Join with another small group or return to the large group and share some of your responses to the questions.
3. Read 1 Corinthians 12:4-11 aloud. Talk about what you have read. *What gifts has God given for healing? What are our responsibilities as individuals and as a community for exercising those gifts?*

Between Sessions

- Read “A Short History of Social Ministry Organizations” (Content Sheet 4). Note some insights you may want to share at the next session.
- Read or reread pages 10-12 of the social statement. Make notes of your answers to the questions on the hand out.

- Do some research on the health care system in your community. What is working? What needs to be implemented or improved? Interview several others on these issues and bring their comments to share.

Closing:

Use a hymn like “O Christ the Healer, We Have Come” (*LBW* #360) or another hymn, psalm, or prayer.

Session Four

Envisioning a Health Care System

A health care system should have the explicit purpose of: promoting and improving the health of all people; reducing the impact and burden of illness, injury, and disability; and promoting healing, even when cure is not possible.

[“Caring for Health: Our Shared Endeavor” page 12]

Session Objectives

In this session we want to:

- Consider the components of an effective health care system.
- Review the history of health care coverage in the United States.

In Preparation

- Read through all session materials
- Check room setup to comfortably accommodate expected number of participants

Materials Needed

- Paper and pens/pencils for participants to make notes during small group discussion
- Bibles for each participant or copies of Luke 10:1-9
- Hymnals for each participant if using

Session Plan

Opening:

Open with prayer. You might use a shared prayer, allowing each person to add a petition as they are willing. Then read Luke 10:1-9 aloud.

Getting Started

- Review: *What did you learn from the last session that is particularly helpful to you?*
- Share your reflections on assigned readings. *What did you learn about social ministry organizations in your community? What is the connection between the what you read and the work of SMOs? How can or does your congregation support SMOs?*
- Share some of your notes from your health journal, if you are willing.

Study and Discussion

1. Read pages 12-17 of the social statement: “Toward a Better System of Health Care Services.” Note any statements you find surprising or challenging. In groups of two to three share your reactions to this section. Then, discuss the following statements.
 - *What public health services are available in your community? How can one access these services?*
 - *What experiences have you had getting—or trying to get—the health care you or a loved one needs? Did the care you received reflect the components for whole patient care outlined in the social statement?*
 - *What is your experience in being a caregiver for a family member or friend? From where did you receive support for this task?*

Share one or two insights you gained from your small group discussion.

2. Ask participants to read or reread Content Sheet 4: “A Brief History of Health Care Coverage in the United States.” Talk about the following questions:
 - *What surprised you about this information?*
 - *Do you know people who do not have health care coverage? What has been their experience in seeking medical care?*

- *What are your fears and/or concerns about the current health care system?*
3. Read page 12 of the social statement: “Advocacy.” Review the earlier reading from Scripture (Luke 10:1-10) and its call to “cure the sick.” *How does this text relate to page 12?*

Between Sessions

- Read or reread the whole social statement and/or read pages 18 to middle of page 21 of the statement. Mark questions and concerns that remain for you and bring these to the next session.
- Collect any newspaper clippings, magazine articles, and reports from TV, radio, or Internet research that you find during the next week pertaining to health care or health insurance.
- Continue your health journal.

Closing:

Use a hymn like “O God, Whose Will Is Life and Good” (*LBW* # 435) or another hymn, psalm, or prayer.

Session Five

Health Care: A Matter of Love and Justice

“We urge all people to advocate for access to basic health care for all and to participate vigorously and responsibly in the public discussion on how best to fulfill this obligation.”

[“Caring for Health: Our Shared Endeavor” page 20]

Session Objectives:

In this session we want to:

- Reflect on access to basic health care as a human need and a matter of justice.
- Understand the current crises and its implications for the future.
- Develop a framework for evaluating new models as they emerge in the public debate.

In Preparation

- Read through all session materials
- Prepare large sheet of paper and tape or bulletin board with tacks for display of newspaper clippings you may have brought
- Check room setup to comfortably accommodate expected number of participants

Materials Needed

- Paper and pens/pencils to make notes during small group discussion

- Bibles for each participant or copies of Matthew 11:4-6
- Hymnals for each participant if using

Session Plan

Opening:

Open with prayer. You might use a hymn like “The Church of Christ, in Every Age” (LBW # 433) or “Here in This Place” (WOV #718).

Getting Started

- Share the results of your research during the past week. Tape clippings to a large sheet of paper or pin to a bulletin board. Take turns sharing what you found most interesting in the article you selected. *How do the issues raised in the media reports fit or not fit with the “Vision of Health Care” described in the social statement?*
- Look again at the “Purposes of this Statement” (page 5 in this guide). *How have the purposes become clear to your in your study? What have you learned that you can share? What questions or tasks remain?*

Study and Discussion

1. Read Matthew 11:4-6. Jesus connected healing and justice in his mission both when he announced it at Nazareth (Luke 4:16-21) and when he tells John’s disciples what his mission has so far accomplished. As you reflect on the text, discuss these questions:
 - Think about all the healing stories in the Gospels you know. *Who had access to Jesus’ healing ministry? Discuss some examples. What if anything do you conclude from these biblical examples?*
 - *How should Jesus’ action (and the actions of his followers) inform how we distribute access to health care today?*
2. Look at Content Sheet 5: “Insuring America’s Health: Principles and Recommendations.” Read the report and then move into groups of two to three. Discussion questions:
 - *What did you find surprising or challenging in this report?*

- *How do the principles for evaluation suggested in the report fit with the vision for a health care system described in the social statement?*

Share one or two insights from your conversations with the whole group.

3. *In an ideal world, what would our health care system look like? Describe it as completely as you are able. What do we need to do as individuals—as a congregation—in our community or as a nation to move toward that kind of system?*
4. *What have you learned from this study that will help you with your personal health? As you help others with health issues? As you consider the health care system in your community and in the nation?*

Moving Toward Action

- Continue with your health journal. Pay particular attention to actions you can take to improve your own health and that of those around you.
- Choose one action you can carry through on, either as an individual or along with others to improve health care in your community.
- Join others to encourage the leaders of your congregation to do a review of actions you are taking and can take together to improve the health of your members and others in your community.

Closing:

Read pages 22-23 (Conclusion) of the social statement together. Join in prayers for health and healing and for other concerns raised by your reading and this study. You might use the “Prayer for Health. . .” on page 16 in this guide (Session 1) again.

Content Sheet 1

Guiding Perspectives for Social Statements¹

Social statements are theological documents.

They “arise from and address the changing circumstances of our world in light of God’s living word of Law and Gospel. With the aid of contemporary experience and knowledge, they bring this church’s understanding of its faith to bear on social issues.”

Social statements are teaching documents.

These documents “bring together the realities of our world, the experience of Christians living their vocation, and the convictions of faith. Social statements give voice to the prophetic mandate of this church, its calling to care for God’s world, and its commitment to reason together on social concerns.”

Social statements involve this church in the ongoing task of theological ethics.

“In these documents, this church addresses the question: What ought we as Christians and the Church think and do about this social issue?, Social statements seek to discern God’s will for today, offering insight and direction on how people should view an issue and act justly in relation to it.”

Social statements result from an extensive, inclusive, and accepted process of deliberation throughout this church.

“They are shaped by careful and critical listening to this church and to society, as well as to other church bodies and ecumenical organizations, both in this country and around the world.”

Social statements guide the institutional life of this church.

“They set forth the principles and directions that the Evangelical Lutheran Church in America considers necessary to govern the internal and external practices of its social responsibility in accordance with its understanding of God’s will.”

Social statements, intended to be used widely in the life and mission of this church, reflect awareness of the various audiences and ministries which they are to serve.

“To help stimulate consideration of social issues in congregations, their language is clear and appropriate for congregational life.”

1 ELCA, “Guiding Perspectives for Social Statements” (c. 2000).

Content Sheet 2

Some Definitions of Health

1. Whatever is the normal functioning of our bodies (or any of our cells, organs, or body's systems)²
2. The "well-working" of our bodies as a whole, seen especially in how well they perform their various functions.³
3. The ability of a person to realize his or her important goals in particular circumstances.⁴
4. "A state of complete physical, mental, and social well-being, and not merely the absence of disease" which permits people "to work productively, and to participate actively in the life of the community in which they live."⁵
5. "The total well-being of persons . . . the integration of each person's spiritual, psychological, and physical dimensions . . . the harmonious interrelationship of environmental, nutritional, social, cultural, and all other aspects of life."⁶
 - Which dimensions of human life and well-being does each emphasize and which does each downplay?
 - Is one definition better than another or better in some circumstances, but not in others?
 - Does one definition better reflect a Lutheran perspective?

Who might find each one appealing? Of these five definitions—and there are many more—the first two focus on how well our bodies function physically. The third ties health to an individual's ability to reach personal goals. Definitions four and five attend to dimensions of

health beyond the solely physical and the purely personal, drawing in mental, spiritual, and social dimensions. The first few identify health with the way bodies “normally” function, but they don’t take into account mental or social dimensions. And many people with chronic diseases or handicapping conditions may see themselves as healthy. Defining health in terms of the ability to reach life goals, as the third definition does, might work better if it took into account the difference between worthy and less-than-worthy goals.

Source:

Our Ministry of Healing: Health and Health Care Today © 2001 Evangelical Lutheran Church in America, pages 17-18

- 2 Christopher Boorse, *The Concept of Disease* (Dordrecht: Kluwer Academic Publishers, n.d.), cited in Mark J. Hanson, “Defining Health and Health-related Concepts: Conceptual and Theological Considerations,” *Word & World*, 21:1 (Winter, 2001), p. 25.
- 3 Leon Kass, “The End of Medicine and the Pursuit of Health,” in *Concepts of Health and Disease: Interdisciplinary Perspectives*, ed. Arthur L. Caplan, H. Tristram Engelhardt Jr., and James J. McCartney (Reading, Mass.: Addison-Wesley Publishing Co, 1981), p. 18.
- 4 Lennart Nordenfelt, “On Medicine and Other Means of Health Enhancement: Towards a Conceptual Framework,” in *The Goals of Medicine: The Forgotten Issue in Health Care Reform*, ed. Mark J. Hanson and Daniel Callahan (Washington, D.C.: Georgetown University Press, 1999), p. 72.
- 5 World Health Organization, *Constitution* (Geneva: WHO, 1946), and “Health for all in the twenty-first century” (Geneva, WHO, 2000), p. 2.
- 6 Office of Research and Analysis of the American Lutheran Church, “Health, Life, and Death: A Christian Perspective” (Minneapolis: American Lutheran Church, July, 1977), p. 2.

Content Sheet 3

What is Health?

Understanding health from a theological perspective

- Health is a gift; so is healing. Neither is the result of individual achievement alone, although personal actions and practices do significantly affect health. When healing occurs or health is maintained, God “delivers” the gift by means of a whole network of people and institutions working together? patient, health care institutions, government, family, community, and church. Yet, when health fails as it finally does for all of us, God does not abandon us. “Imperfect health”(which is as good a state of health as we ever have) does not mean we are forsaken by God. On the other hand, being in relatively good health is not a particular sign of God’s presence or favor, or an indication of a person’s greater holiness or moral worthiness.
- Health is finite; it has its limits because human beings are finite. God sets us *within* creation, within a world of other creatures and other human beings to which we are related in families, communities, and countries, as well as in ecologies and economies. Our lives are also of limited in time, bounded by conception and death. Health is not the final end or aim of our life; it is not the most important thing in life. Rather, its importance? which indeed is real? is finite, just as health itself is finite.
- Health is “neighborly”; we might even say it is “public.” God makes us social creatures and commands us to love God and our neighbors. Both our health and our ill-health matter to others and

affect them, just as theirs matter to us and affect us. Health is not only (perhaps not even mainly) a private concern.

- Health is a social responsibility. Besides the responsibility each of us bears for our own health, we are also responsible to others, and to God, with respect to matters of health. Health is not just about me and mine; it is also about us and ours, and how we are responsible both to and for each other.
- Health is a matter of justice among people in society. We live in a world of relationships woven out of mutual connections, responsibilities, and obligations to others, all of us before God, as well as a world in which we may have certain rights. Health is about more than rights or privileges guaranteed to some but not to others because some have the economic means to claim them, or because they are genetically lucky, while others do not or are not.
- Health is more than a marketplace item, more than just another commodity to be bought and sold or insured, although it is increasingly common to treat it as such. It is also a public good that we have in common for which public health agencies are typically responsible. Health as a public good is a concept whose theological underpinnings lie in the commandment to “love your neighbor as yourself.” The one who gives us this command creates conditions for people to be healthy and calls us to use and enjoy our health as God’s beloved creatures in lives of thanksgiving, praise, service, and obedience.

Source:

Our Ministry of Healing: Health and Health Care Today © 2001, Evangelical Lutheran Church in America, pages 21-22

Content Sheet 4

A Brief History Of Health Care Coverage In The United States

The crisis in health care that we are experiencing today did not just happen, it developed over the years.⁷ Before the 1930s, for example, patients and their families generally paid their medical expenses out of their own pockets in cash. Doctors and other providers charged a fee for the service they provided; this method of payment came to be called “fee-for-service.” During the Great Depression of the 1930s, new businesses were established to provide medical insurance; these companies, forerunners of corporations like Blue Cross, covered a patient’s hospitalization for a limited amount of time. The first HMO was organized in Los Angeles in 1929. At about the same time Henry J. Kaiser started a prepaid group health plan for employees of his construction company in the West which became the model for today’s health maintenance organizations (HMO’s). For several decades HMOs remained a relatively small part of the health care delivery system.

The practice of getting health coverage through one’s employer got a boost during World War II. The labor market was very tight because so many men and women were serving in the military. The government froze wages to help control inflation, but decided not to consider health benefits as earnings, so they were not frozen. Providing health coverage for employees became a popular tool for recruiting and keeping employees. After the war, unions in major manufacturing industries, such as the automobile, rubber and steel industries, made the introduction and expansion of health insurance a key demand in their bargaining talks.

Employer-sponsored coverage spread rapidly throughout the economy in union and nonunion companies alike in the 1950s and 1960s. Although it has fluctuated with the economy, employer sponsored health insurance remains an important popular source of coverage for many

reasons. For one, health coverage on the job also carries significant tax advantages for employer and employee. Amounts that employers pay for their employees' coverage are tax-deductible business expense to the employers. And the money that an employer pays for an employee's insurance is not counted as taxable income to the employee.

Major medical insurance, introduced in 1949 by private insurance companies, became popular with consumers. People paid insurance premiums and the insurer paid the bills. When increasing demand for health care services helped fuel cost increases in health care, employers shifted costs to their employees in the form of deductibles and co-payments. Insurers also assumed more control of what they paid for, setting up contracts with providers for blocs of insured people that established provider reimbursement schedules for various services or procedures. Often providers needed to clear a course of treatment with the insurer before it could be authorized — and reimbursed. Insurance companies also negotiated with pharmacies about what they would be paid for prescription medications covered by their plans.

The Medicare program, established by Congress in the mid-1960s, provided coverage for older Americans and disabled persons. Originally begun as a program to cover visits to the doctor's office, it was eventually expanded to cover hospitalization. People could also select additional coverage options at additional cost to them. The Medicare program set the rates it would pay for various procedures. As elderly people have lived longer, and as health care costs have increased, some additional costs of the program have been shifted to enrollees, some of whom live on limited fixed incomes. Until 2004, Medicare did not cover prescription drugs.

Medicaid, also established in the mid-1960s, provided health coverage to eligible poor people; this federal program is administered by the states. For people on public assistance, their state Medicaid program paid for eligible health care expenses for them and their dependent children. Medicaid coverage was, however, a significant disincentive for some people moving off welfare into jobs in the private sector, where health coverage was frequently unavailable to relatively unskilled, low-wage employees.

In the 1970s, at least in part because of these federal reimbursement programs, health care costs in the United States began to rise steeply, a trend that continued throughout the 1980s and into the 1990s⁸. During the same period, efforts were also made to contain the burgeoning cost of health care. Approaches included self-funded employer health care

plans, shifting more costs to employees, the use of Preferred Provider Organizations (PPOs), point-of-service plans, and managed care plans. These plans tried to control costs, in part by limiting access to certain kinds of treatments and by requiring physicians to seek approval for procedures and treatments from health care systems' "case managers" before prescribing them for their patients.

Welfare reform in the mid-1990s removed many people from public assistance rolls; limited Medicaid coverage after public assistance was terminated provided both a safety net and an incentive to become self-supporting. While many former recipients of public assistance found employment in an expanding economy, many were unable to find jobs with health care coverage. Some obtained coverage under various state-initiated programs for the working poor, although eligibility, as well as coverage, varied from state to state. In 1997, after enacting welfare reform, Congress created the Children's Health Insurance Program (SCHIP) to cover children of the working poor—a program also administered by the states. The application process, frequently long and complicated, discouraged millions of parents from applying.

In 2002 some 46 million children – about two-thirds of the children under age 18 – were covered by a parent's employer sponsored coverage. Some 17.5 millions were covered by Medicaid or SCHIP. More than 8.5 million children were not covered by any program. This number is likely to increase as more and more states begin to freeze enrollment because of budget constraints. By January 2004, six states have taken this course of action.

By 2004 nearly 44 million people in the US lacked health coverage. Almost one in five adults age 18-64 and one in 12 children were without coverage.

Uninsured Myths and Facts

Myth: People without health coverage don't work.

Fact: Eight out of 10 people who are uninsured are in working families

Myth: Most uninsured people in the U.S. are minorities.

Fact: Non-Hispanic whites make up three-fourths of the uninsured.

Myth: Most people without health insurance are poor.

Fact: Almost 29 million of the uninsured in 2002 had household incomes of \$25,000 or more, compared with 14.8 million households earning less.

Myth: It really doesn't matter whether a person has health insurance.

Fact: About 18,000 Americans die each year of treatable diseases because the don't have health coverage according to the highly respected, nonpartisan Institute of Medicine.

Myth: Virtually everyone who works for a large employer has health coverage.

Fact: More than one out of four of the nation's uninsured in 2001 (nearly 10 million people) either worked for a firm with 500 or more employees or were dependents of someone who worked for a large firm.

Sources:

Our Ministry of Healing: Health and Health Care Today, © 2002 Evangelical Lutheran Church in America, pgs. 9-10 (www.elca.org)

Health Care Coverage in America: Understanding the Issues and Proposed Solutions;
The Alliance for Health Reform (www.allhealth.org)

7 Much of the following is based on: Burton T. Beam, Jr. and John J. McFadden, Employee Benefits (Dearborn: Financial Publishing, Inc., 1998), pp. 191-195.

8 Health care costs equaled 13.5 percent of a measure of national wealth known as the Gross Domestic Product by the 1990s. See Gerard F. Anderson and Jean-Pierre Pollier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs*, May/June 1999, pp. 178-192.

Content Sheet 5

Insuring America's Health: Principles and Recommendations

National Academy of Sciences Institute of Medicine

The lack of health insurance for tens of millions of Americans has serious negative consequences and economic costs not only for the uninsured themselves but also for their families, the communities they live in, and the whole country. The situation is dire and expected to worsen. The Committee urges Congress and the Administration to act immediately to eliminate this long-standing problem.

In January 2004 the National Academy of Sciences Institute of Medicine released its final report of a series of five studies on the Consequences of Uninsurance. The report came at the end of a three year process which carefully assessed and documented the nature and severity of the problems resulting from uninsurance. The clinical literature overwhelmingly showed that uninsured people, children as well as adults, suffer worse health and die sooner than those with insurance. Families with even one member who is uninsured lose peace of mind and can become burdened with enormous medical bills.

The committee findings showed that uninsurance at the community level is associated with financial instability for health care providers and institutions, reduced hospital services and capacity, and significant cuts in public health programs, which may diminish access to certain types of care for all residents, even those who have coverage. The economic vitality of the nation is limited by productivity lost as a result of the poorer health and premature death or disability of uninsured workers. The Committee estimated that the economic value lost because of poorer health and earlier deaths among uninsured Americans is between \$65 billion and \$130 billion annually.

The Committee noted that when it began its work in 2000, about 40 million Americans lacked any health insurance coverage, despite the strong economy of the previous decade. Since then, another three million individuals have been added to the rolls of the uninsured.

The Committee found the consistency of the evidence, and the scope and scale of its consequences, compelling. They asked, “Can we afford not to cover the uninsured? Why hasn’t more been done to eliminate uninsurance? Could extension of coverage be achieved through incremental expansions of existing programs or through comprehensive reforms? What should be done?”

“The Committee on the Consequences of Uninsurance envisions an approach to health insurance that will promote better overall health for individuals, families, communities, and the nation by providing financial access for everyone to necessary, appropriate, and effective health services.” The evidence reviewed and developed by the Committee in its first five reports contributed to this shared vision and the following five key principles. The first principle is the most basic and yet most important. The remaining four principles are not ranked by priority.

1. Health care coverage should be universal.

- Everyone living in the United States should be covered by health insurance. Being uninsured can damage the health of individuals and families. Uninsured children and adults use medical and dental services less often than insured people and are less likely to receive routine preventive care. They are also less likely to have a regular source of care than are insured people. Insurance coverage is the best mechanism for gaining financial access to services that may produce better health.
- Uninsured people are less likely to receive high-quality, professionally recommended care and medications, particularly for preventive services and chronic conditions.
- Uninsured children risk abnormal long-term development if they do not receive routine care; uninsured adults have worse outcomes for chronic conditions such as diabetes, cardiovascular disease, end-stage renal disease, and HIV.
- Uninsured adults have a 25 percent greater mortality risk than do insured adults, accounting for an estimated 18,000 excess deaths annually.

2. Health care coverage should be continuous.

- Continuous coverage is more likely to lead to improved health outcomes; breaks in coverage result in diminished health status.
- Achieving coverage well before the onset of an illness would likely lead to a better health outcome because the chance of early detection would be enhanced.
- Interruptions in coverage interfere with therapeutic relationships, contribute to missed preventive services for children, and result in inadequate chronic care.

3. Health care coverage should be affordable to individuals and families.

- The high cost of health insurance is the main reason people give for being uninsured. Nearly two-thirds of people with no coverage have incomes that are less than 200 percent of the federal poverty level. Families in that income group have little leeway for health expenditures, making some form of financial assistance necessary for obtaining coverage.
- Among families with no members insured during the entire year and incomes below the poverty level, more than a quarter paid out-of-pocket medical expenses that were more than 5 percent of income.

4. The health insurance strategy should be affordable and sustainable for society.

- The Committee acknowledges that any health insurance strategy will likely face budgetary constraints on the benefits as well as on the administrative operations. Any major reform will need mechanisms to control the rate of growth in health care spending. There is no analytically derivable dollar amount of what society can afford; that will be determined through political and economic processes.
- The Committee believes that everyone should contribute financially to the national strategy through mechanisms such as taxes, premiums, and cost sharing because all members of society can expect to benefit from universal health insurance coverage.
- To help ensure affordability, the reform strategy should strive for efficiency and simplicity.

5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.
- Insurance should be designed to enhance the quality of the health care system as specified above and recommended by the IOM's Committee on Quality of Health Care in America.
 - A benefit package that includes preventive and screening services, outpatient prescription drugs, and specialty mental health care as well as outpatient and hospital services would enhance receipt of appropriate care.
 - Variation in patient cost sharing could be used as an incentive for appropriate service use because it can influence patient care.

Using the Principles

The Committee's research on the problems related to uninsurance demonstrates conclusively that there are benefits for the nation and all its residents from eliminating uninsurance and ensuring coverage for everyone. Based on a review of past incremental and disjointed efforts to extend coverage, the limited progress made, and the remaining 43 million uninsured, the Committee concludes that health insurance coverage for everyone in the United States requires major reform initiated as federal policy.

Achieving universal coverage across the country will require at a minimum federal policy direction and financial support. The new system would not necessarily be controlled wholly at the federal level or operated solely through a government agency. The Committee presents the preceding set of principles to be used in clarifying the public debate about approaches to extending coverage. The principles provide objectives against which to measure various proposals. The Committee does not endorse or reject any particular approach to solving the problem of uninsurance, but recognizes that there are many pathways to achieving its vision. The Committee recommends that these principles be used to assess the merits of current proposals and to design future strategies for extending coverage to everyone.

Imagine what the country would be like if everyone had coverage—people would be financially able to have a health problem checked, to seek preventive and primary care promptly, and to receive necessary, appropriate, and effective health services. Hospitals would be able to provide care without jeopardizing their operating budget and all families would have security in knowing that they had some protection against the prospect of medical bills undermining their financial stability or creditworthiness.

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Notes

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