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Access to Health Care by the Poor: Two Solutions to a Growing Crisis

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Health Care Profession

As part of the overall solution to the health care crisis facing the poor, the Catholic Health Association considers first the role of the health care profession. In particular, the responsibility of Christian professionals to the poor is realized in three ways: service of the poor, advocacy on their behalf, and renewal of Catholic hospitals' mission to the poor.¹

The CHA proposes that each Catholic health facility or group manifest its option for the poor in the annual planning and budgetary process, so that decisions are evaluated in terms of their impact upon the poor.

Next, it calls upon Catholic health facilities to be advocates for the poor. In particular, the CHA should formulate annually a federal program on health care for the poor which it should then sponsor in the proper forums. Moreover, each Catholic health facility should seek to promote health care legislation for the poor with state and federal legislators. Finally, the CHA and Catholic health associations should collaborate with others in their advocacy efforts on behalf of the poor.

The CHA also recommends that Catholic health care professionals develop creative, spiritual, and educational programs that will assist them to better understand the needs of the poor, as well as to experience the poverty of spirit in which the power of God is found. Both the CHA and local health care facilities should set up such programs.

The American Hospital Association is more restrained in delineating the responsibility of the health care profession toward the medically indigent. Hospitals are to maintain their traditional commitment to provide medical care to those in need, including the medically indigent.² They are to provide emergency care to all people and make proper

arrangements for transfer if the needed services are not available. However, the obligation to provide non-emergency care without compensation is to be balanced by available resources, as well as by the hospital's obligation to the non-indigent and to the community at large. Finally, hospitals have a particular duty to work for adequate public and private funding for the medically indigent.³

Community

Church's Response Discussed

The CHA next discusses the appropriate response of the Church to the health care needs of the poor, particularly the unique roles of the parish, the diocese, state organizations, and national Catholic groups. In this section, the CHA construes "health" broadly so as to include proper food, clothing, shelter, sanitation, immunization, freedom from chemical dependency, and mental well being.⁴

At the parish level, the CHA recommends that the local community identify the health concerns of the parish poor and develop programs to address them. Diocesan groups should study the health care needs of the poor, the resources available to them, and the ability of church groups to coordinate activities on behalf of the poor. State Catholic conferences should sponsor parish and diocesan proposals, as well as support state and federal legislation which improves health care for the poor. Finally, the National Conference of Catholic Bishops should revise its 1981 pastoral letter on health care so as to better take into account the health care needs of the poor. Unfortunately, the CHA makes no specific recommendations that focus upon the talents, expertise, and resources of non-Christians, non-Catholic charities, and other social groups in American society who are able to contribute to the health care of the poor.

Although the AHA acknowledges that care for the medically indigent is the common responsibility of all members of society,⁵ it makes no specific proposal which manifests this common responsibility. There are reasons for this. Despite the fact that the AHA does not explicitly define "health care", the AHA document seems to assume a rather narrow understanding of the term—physical well-being maintained through proper functioning medical facilities. Thus the broader opportunities for health care set out in the CHA document do not reflect the AHA view of care. Consequently, the role of the charitable groups and individuals, except as sponsors for the payment of uncompensated care, is not explored. Moreover, since the AHA is not affiliated with a church organization or a charity, it is perhaps more reticent to make specific recommendations for such social groups as churches and charities. For the AHA the members of society responsible for serving the poor become the government, employers, private insurers, and providers.

Similar Roles Proposed

The CHA and the AHA propose similar roles for government in solving the health care crisis which is currently affecting the poor. For the CHA the long-term solution is a federal one; interim solutions include participation by both the federal and state governments and by private insurance. The AHA long-term solution is two-fold: increased employer-provided insurance coverage and a restructured public insurance system. Interim solutions include participation by federal, state and local governments, insurers, employers, and providers. More specifically, the CHA makes the following recommendations. Noting that the poor's access to necessary health care can be expanded in one of two ways—federally mandated universal health insurance or direct payment to hospitals and other providers—the CHA argues for the former. It contends that universal health insurance is more expedient, will encourage the poor to seek necessary health care, and removes the stigma of public relief. As interim solutions, the CHA recommends three primary strategies.⁷ Congress and state legislatures should expand Medicaid and state-sponsored insurance coverage for the newly unemployed and the working poor. Government should provide direct payments to hospitals which serve a disproportionately large number of the uninsured poor. Finally, it should allocate existing health care resources more equitably on behalf of the poor.

The CHA proposes other interim solutions as well.⁸ In order to provide better health care access to the poor, federal health grant projects, like maternal child health and nutrition programs, should be expanded. Moreover, in order to more equitably distribute the social responsibility for health care, Congress should allow states to subject self-insured employers to the same rules that affect those employers whose health insurance premiums are subject to state tax.

In contrast to the CHA proposals, the AHA recommends a two-pronged long-term solution: expanded private insurance coverage and a restructured and extended public insurance program.⁹ With regard to the first of these, the AHA recommends a combination of government and private sector responses that would create sufficient incentives for increased private or work-related health insurance coverage.¹⁰ The federal government should consider making the tax deductibility of health insurance premiums by employers and employees contingent upon the adoption of certain explicit insurance benefits. Mandatory health insurance coverage for family members, minimum health care benefits, and continued coverage for workers receiving unemployment compensation could be among these. Private insurers and providers should work to reduce the cost of insurance by adopting more effective delivery and financing procedures. Finally, insurers and employers should adopt better methods to underwrite insurance for small employers, for high risk individuals, and for catastrophic illnesses.

Second Part of Solution

The second part of the long-term health care solution for the indigent rests upon a residual public insurance program.¹¹ First, the Medicaid program should be restructured so that Medicaid coverage for those not eligible for Medicare would be separated from programs which relate to the Medicare-eligible indigent. Medicaid for those not eligible for Medicare would be available to anyone desiring coverage. In order to reduce the cost of the program and to deter those enrolled from passively accepting government cutbacks, a premium would be charged to those who are able to pay. Benefits would be comparable to those provided by Medicare and would be based upon the particular health needs of each individual. As proposed by the AHA, those enrolled in the public plan would be given choices with regard to health care providers and systems. Health maintenance organizations, independent practice associations, and preferred provider arrangements would be among these. Capitation arrangements or other devices for full or partial risk bearing would provide the bases for payment. The AHA recommends a payroll tax to be paid equally by employers and employees to fund the program. So as to create a positive incentive for the acquisition of work-related insurance, a partial rebate would be granted to those who obtain private insurance. In effect the public insurance system would compete with private insurance in the areas of cost, benefits, and overall efficiency, and each system of insurance would serve as a check upon the other.

Because the adoption of a long-term solution is not yet foreseeable, the AHA proposes a series of diverse and flexible short-term initiatives which would support and strengthen the long-term goals.¹² The federal government should adopt tax incentives, including a personal income tax deduction or exclusion for employer-paid health insurance premiums, where such insurance covers all dependents. The deduction would be available to all individuals, both those who itemize and those who do not. Moreover, the federal government should require employers to continue coverage for laid-off workers as part of unemployment compensation. States, on the other hand, should encourage the creation of multiple-employer insurance arrangements to provide insurance coverage for the self-employer and employees of small firms. Finally, private insurers, employers, and providers should work to develop affordable health insurance, especially for small employers, both by creating multiple-employer insurance arrangements and by improving financing and delivery systems so as to reduce per capita costs. Other short-term incentives would extend coverage under the Medicaid program.

Work with Government

According to the AHA, employers and insurers should work with government to obtain adequate funding for indigent health care. In cases where public funds are not available, employers should work with health

care providers and insurers to establish community foundations or trusts to fund such care. In addition, when employers and insurers negotiate payment schedules with providers, they should make explicit provision for the cost of charity care and bad debts which is incurred by health care facilities.

Finally, hospitals should maintain their commitment to provide care for those in need, including the indigent. Such commitment requires that they raise the public's awareness of the problem of medical indigence, and work with employers, insurers, and government to find solutions.

Comparison of CHA/AHA

Although both the CHA and the AHA argue for a long-range solution to the problem of medical care for the poor, each emphasizes different dimensions of that solution. The CHA envisions a broad role for those engaged in the health care profession, as well as for church groups like the parish and the diocese in achieving a lasting result. Together they have a responsibility to reach out to the poor, to provide for them in planning and budgetary processes, and to attend to their health care needs. Within this scheme, the duty of individual Christians to promote health care is recognized. Citing the American Catholic bishops' pastoral letter on health care, the CHA states that "Health has to do with more than strictly medical concerns. The restoration of health and maintenance of good health are not solely the responsibility of doctors, nurses and other professionals. We all bear a responsibility in this regard, both as individuals and as members of larger social and religious institutions."¹³ The CHA, however, is less specific in discussing the permanent role of the federal government. It asserts that "when the private sector—the church, health care facilities, employers, insurers, and charity—cannot help the poor obtain adequate health care, then the responsibility to ensure equitable access rests with the local, state, and federal governments."¹⁴ But this government responsibility is then simply proposed as one of two long-range strategies: federally mandated universal health insurance or direct government payment to providers for health care services to the poor.¹⁵ In either case, concrete government recommendations are not offered as long-term, but as interim strategies. As such the CHA focuses more upon alleviating the current crisis than upon providing a detailed, long-range plan for government sponsorship of health care for the poor.

The format of the AHA recommendations suggests a more limited scope of public responsibility for health care. Although the AHA document states that "The care of the medically indigent is the responsibility of all members of society,"¹⁶ the parties which are then identified are those traditionally identified with providing health care. "If public discussion of medical indigence is to be more than empty rhetoric, the responsibilities of those most directly involved in financing and providing that care—government, employers and private insurers, and providers—must be clearly identified."¹⁷ The obligation of charities,

churches, and individuals to provide health care is not explored by the AHA.

However, the AHA is more specific than the CHA in offering a long-range solution to the problem of care for the poor. The long-term goal is described, concrete proposals to carry out the plan are made, and the roles of private insurance and government are discussed in some detail. The short-term initiatives are ancillary to this goal; the thrust of the AHA document is upon a long-range, not a short-term solution. "The major challenge to policy makers is the identification and adoption of short-term policies that lead toward a lasting solution to the problem of medical indigence. The extent to which an initiative is consistent with a long-term solution should be the primary criterion that determines whether it is adopted."¹⁸

For both groups, health care for the indigent is premised in the long run upon the current system of private and public insurance which would be made available to everyone. As proposed, the primary health care delivery system would continue to be the hospital. However, the CHA envisions a permanent role for the hospital as not only a deliverer of care, but also as an advocate for the poor. At the same time, it understands health care more holistically and seeks to utilize existing Church structures like the parish and diocese to meet the physical, emotional, material, and spiritual needs of the poor.

Both Groups Recommend

The recommendations of both groups attempt to resolve this health care dilemma in ways which will prove satisfactory for meeting the access needs of the poor, as well as for safeguarding the financial integrity of hospitals. But here, also, the viewpoints and solutions of each group must be nuanced. The CHA begins its discussion with the Catholic Church's preferential option of serving the poor and attempts to structure its report in light of this responsibility.¹⁹ The AHA, on the other hand, begins with the ramifications of medical indigence upon providers, insurers, and society at large; responsibility to provide care for the poor is not disclaimed, but the issue of health care to the poor is framed more in terms of the institutional consequences of medical indigence.²⁰ The CHA recognizes that providing health care to the poor does not exempt Catholic institutions from competent management and sound fiscal practices, especially in these times of a competitive health care market. But even here "this requirement must always be balanced against Christ's example of solicitude for the poor, the aged, the sick—the easy victims of an unrestrained, competitive entrepreneurial spirit."²¹ A successful health care facility, then, must operate with more than productive efficiency; it must seek to make the needs of the poor a priority. "The fundamental norm is this: What is happening to the poor as a result of this action? This is not the only and may not be the most important question, but it is essential if the facility is to address service of the poor."²² The CHA recognizes that

such an understanding of a facility's health care mission will not be without its sacrifices. "The application of Christian values at such a time is extremely difficult for Catholic hospital administrators and boards. It may even involve suffering, as Christ did, to bring good news to the poor. Catholic institutions can face these challenges, however, in the faith that the Spirit of God dwelling among us can promote the creativity and power to heal individuals, institutions, and society."²³

In discussing the individual hospital's responsibility to the poor, the AHA approach is more pragmatic. It argues that the ability of a hospital to care for the poor is determined by resources. It acknowledges that every hospital has a responsibility to provide emergency care to all people, but its obligation in non-emergency situations is more limited. "A hospital's obligation to provide non-emergency care without compensation is constrained by the resources available to it, and must be balanced with its obligations to non-indigent patients and the community it serves."²⁴ For the AHA, it seems that the hospital's responsibility to the poor is one obligation among many, not the least of which are the health care provider's obligations to non-indigent patients and to the community at large. The CHA document does not emphasize this obligation to the broader community as part of a hospital's overall mission.

Both documents, then, seek to find solutions to the problem of health care for the indigent. The CHA seems to focus on access for the poor; the AHA on the equitable and effective distribution of cost. Both issues, of course, are profoundly related. In the end, it is really a question of emphasis. The answers which they give, however, reflect different understandings of what health care is and who has the responsibility to provide it.

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