Pursuing the possible: Religious voices on health care

by Robert D. Francis in the July 14, 2009 issue

On May 13, I lingered in Upper Senate Park, just north of the U.S. Capitol, hearing New Orleans jazz coming from down Constitution Avenue. Then I saw the brass band leading a lively procession of hundreds of nurses, other medical professionals and patient advocates. It was the National RN Day of Action, a lobby day for several state nurses' associations—among the most ardent proponents of single-payer health care.

The previous day, the Senate Finance Committee held the last of three roundtable discussions on health reform, and for the third time, the single-payer perspective lacked representation among the experts tapped to testify. Also for the third time, single-payer advocates planted in the audience interrupted the proceedings, demanding that their perspective be heard—and were promptly escorted out by police. After the fifth single-payer proponent stood to speak, committee chair Max Baucus (D., Mont.) said that all perspectives were welcome and that he would make time to meet with them. At the rally I attended the next day, speaker after speaker reiterated the demand for a seat at the table.

As of this writing, drafts of the health- care reform bill have been made public, and the relevant House and Senate committees are expected to formally introduce legislation in a matter of weeks. The general outline has been known for some time. Congress's approach closely mirrors the Obama administration's and is influenced in part by Massachusetts's effort to provide universal coverage. The idea is to build on the current system while working to expand coverage, increase efficiency, reduce waste and control costs. A single-payer plan, however, is off the table—to the distress of those nurses in Upper Senate Park as well as many in mainline denominations.

I work on domestic policy for the Evangelical Lutheran Church in America, and I work closely with other mainline public policy offices. The churches are united in their call

for access to quality, affordable health care for all people, but they differ in how specific they are about how to get there. My colleagues and I, charged with representing these denominational positions, find ourselves at different starting points.

The Presbyterian Church (USA) has an official single-payer resolution. The PCUSA's Leslie Woods has written that single-payer is "a good vision of how to bring God's *shalom* to the many, rather than the privileged few," but she knows it's "an unlikely political conclusion." The challenge is to honor the denomination's single-payer mandate—and its passionate supporters—while also participating constructively in the debate.

For some organizations the inclusion of a publicly sponsored health plan is nonnegotiable. These include some groups that support single-payer, such as the United Methodist Church. "Without [a public plan], there is not true reform," said Cynthia Abrams of the UMC, but only "putting Band-Aids on a broken system." Even on this point, however, denominational advocates have to balance some of the same interests they do with single-payer.

As a representative of a church without a prescribed mechanism for health-care reform, I face a different issue: balancing this policy with challenges from vocal single-payer activists. I recently called a Lutheran pastor for suggestions on who could do some pro-reform radio ads. Instead of enthusiasm, I got a sharp question: "That depends. Are you supporting single-payer or not?" Some think the church should be explicit about means as well as ends. Even in my home congregation in DC, I am quickly pressed on what the church is saying about single-payer.

Like the ELCA, the Episcopal Church has a less prescriptive policy approach. Advocate DeWayne Davis explained that his church has "refrained from drawing a line in the sand" to avoid "squandering what credibility and influence we have in a town where private, monied interests get heard more often."

While this may sound overly pragmatic, advocacy work requires constantly discerning "when to support and when to confront society's cultural patterns, values, and powers," as the ELCA statement on the church in society puts it. Navigating the distance between incrementalism and revolution finds denominational advocates juggling fidelity to church policy, a panoply of passionate opinions in the pews and the realities of Capitol Hill.

The work of the United Church of Christ's Barbara Baylor exemplifies life in this liminal space. She recently proposed a single-payer resolution—a surprising move to make at the very moment of a supremely pragmatic national debate. But Baylor had come to believe that "it was time to move beyond proclamation to action" on a specific means of reform.

Baylor doesn't think the church's approach to the national debate will change if the UCC approves her resolution. "What *would* be enriched," she explained, "is the dialogue among UCC congregations and other organizations that embrace single-payer."

This summer might be the best opportunity in a generation to achieve significant health care reform of *any* kind. There are more pieces in place now than in the early 1990s, the last time anything of this scale was attempted. And a desire to avoid that effort's mistakes is guiding the approach of the current Congress and administration—an approach that has left single-payer advocates in the cold.

The Clinton administration went after too much too fast. This played poorly not only with the powerful industries that stood to lose a lot but also with individuals—even many unsatisfied with their coverage and health—who feared that upsetting the applecart altogether would leave them worse off. More than 80 percent of Americans have health insurance of some kind. Faced with a choice between an imperfect but familiar present and an unknown future, many reliably choose the former.

But an incremental approach may be the only way to achieve reform. In the January 26 issue of the *New Yorker*, Atul Gawande observes that neither Great Britain, France nor Switzerland achieved its universal health-care system by policy fiat. Instead, each built on existing health systems, and they arrived at three vastly different structures. Gawande argues that we too need to build on what we have, even if it's not an ideal foundation and is largely an accident of history. Getting where want to be will be gradual, as it was for others.

A more dramatic change would be unwise, according to Gawande, and even potentially deadly. Hundreds of millions depend on our current troubled system. Even the most carefully planned overhaul would cause massive disruption—and with something as fundamental as health care, even minor hiccups present great risk. Gawande cites the 2003 change in the prescription-drug program for the elderly, which meant new drug plans for 25 million people. When the changes took effect in

2006, the result was chaos. Tens of thousands couldn't get prescriptions, and 37 states faced public-health crises. Our health-care system may be "an appallingly patched together ship," says Gawande, but we cannot simply dry dock it for a few months or even an afternoon while we rebuild. "If we get things wrong, people will die," he writes. "This doesn't mean that ambitious reform is beyond us. But we have to start with what we have."

President Obama and the other Democrats guiding the health-care ship seem to be on the same page as Gawande. Throughout his campaign, Obama stressed that those who like the coverage they have can keep it. He and Senator Baucus have both talked about finding a uniquely American solution to our health-care woes. And a recent briefing paper from the Senate's Health, Education, Labor and Pensions (HELP) Committee is subtitled "Strengthening What Works and Fixing What Doesn't." No revolutionary language here.

Another conviction from the 1993-1994 experience is that we simply cannot come up completely empty again. In the last 15 years, the number of uninsured has grown and countless thousands have died from lack of adequate access to health care. It's hard to argue that we are better off now than we would be if we'd accomplished something—anything—then. The next few months might be the best chance in a generation for even incremental change, so those shepherding the process are especially sensitive to making sure the ball moves forward, even if not as far as many would want.

On June 3, Baucus made good on his pledge to meet with the single-payer advocates who had disrupted the Finance Committee hearings. Not surprisingly, he admitted that he was wrong to dismiss single-payer out of hand, but he also made it clear that it will not be part of the committee's bill. It looks as though each committee drafting legislation is including some sort of public plan, and Obama recently reiterated his support for a public option. But single-payer remains out of play.

This summer, denominational advocates are pondering how to move forward in a way that stays true to church policy and relevant to the larger debate. Whichever specific proposals church groups eventually support, we agree on this: any legislation will be a success only if it improves care for the nation's most vulnerable.