INTERCOMMUNITY PEACE & JUSTICE CENTER

a matter of spirit

This issue: Health Care

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Transforming Hurt Into Hope

Diana Bader, OP

Stories of illness and healing touch our lives. There are stories of people who have been freed from terrible diseases through the wonders of medical science; and there are stories of those without the means for basic health care whose lives are cut short. When these experiences intersect our own life stories, we come to appreciate that health care is not a "take it or leave it" option. It is an ingredient of hope and confidence in life. When we are ill or disabled we trust that we will receive the care we need; when others look to us for care, we have confidence that we will have the resources to serve them. In the words of Paul, "Blessed be God… [who] comforts us in all our affliction and thus enables us to comfort those who are in trouble, with the same consolation we have received from God." (2 Cor. 1:3-4)

Our Challenges

We have challenges—historical, economic, political, scientific, and ethical, among others—all interrelated. Three critical areas where the continuing public dialogue needs to be as much about ethical principles as it is about economic and political considerations are distribution of and access to health care resources, end-of-life care as an illustration of the best and worst we offer one another, and the role of Catholic health care institutions as they reflect and shape the public face of health care.

The Ethics of Access

The fundamental ethical issues in health care are availability and access. Adequate health care makes it possible to pursue life's goals and to seek fulfillment of our human vocation within community. Even where illness and disability compromise the fullness of life, access to effective health care can mitigate the burden of these conditions.

"Human understanding nurtured by compassion and generous concern for others is the best formula."

On the societal level, this means recognizing health care as a social good to which members have a right and assuring a reasonable allocation of resources in accord with the principle of the common good. Catholic Social Teaching is emphatic on this matter. So at odds with the U.S. focus on individualism, the common good calls for the equitable distribution of benefits and burdens such as health care and taxes. It flows from the premise that human society flourishes to the degree that all members have access to the resources required for optimal human development.

On the personal level, it is the responsibility of the individual to exercise prudence and reasonable care in preserving health, and in the appropriate use of community resources for health care when needed.

Perhaps the root cause of the continuing health care tragedy in the U.S. is implied in the words of Martin Marty (1979): "A moral society will be a society of participants rather than spectators—to care for one another is the route to fulfillment for self. The real sin is indifference—with no caring there can be no relationships." Do we really care about those who are left out of the health care delivery system and fall through the porous safety nets?

Healing in the Face of Death

In his pastoral letter on Catholic health care, "A Sign of Hope," the late Joseph Cardinal Bernardin described his personal experience of terminal cancer as one of "disorientation, isolation, a feeling of not being 'at home' anymore." Through prayer and the support of family and friends he "came to believe in a new way

that the Lord would walk with me through this journey of illness that would take me from a former way of life into a new manner of living."[1]

Catholic teaching on end-of-life care is guided by recognition of the intrinsic worth of each human life; belief that life is not an absolute good, but "finds its perfection only in eternal life"[2]; and affirmation of the physical, spiritual, emotional, and social dimensions of the whole person. Because dying and death are painful topics in U.S. society, serious conflicts arise on a number of fronts.

First, Durable Power of Attorney for Health Care Decisions and other Advance Directives would help prevent bedside arguments about the patient's preferences and avoid protracted, costly litigation as family members dispute among themselves or with health care professionals. To struggle with such critical decisions is not unreasonable; to anticipate and prepare for them is a matter of prudence. Today, the majority of citizens have yet to take responsibility for this part of their life journey.

Second, giving primacy to cure at all costs sadly ignores the broader goal of healing. Excessive and expensive medical treatments may be pursued with little or no benefit to the patient, while the deeper spiritual, emotional, and social needs are neglected. When one hopes for and expects a cure, it is painful to accept a shift in focus to a 'new manner of living'. There is an obligation to utilize available therapies as long as they do not impose excessive burdens of pain, cost, and separation from family. When considering the good of the whole person, however, some aggressive treatments may ethically be omitted. "…it is permitted to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."[3] At this point, care should shift to relief of pain and suffering to ease the burden of dying.

Third, our development to fullness as human persons is not a solitary process; it involves the communities of which we have been a part. At the end of life it is critical to continue these relationships. When care is holistic it is community-based as well as individually focused. Unfortunately, institutional care that isolates the individual and regards family and friends as an inconvenience is not uncommon. Selecting the most appropriate setting for care and engaging multiple caregivers is part of providing the healing environment in which individuals can prepare for their final transition. End-of-life care is a complex reality that is not easily reducible to a few directives. For this reason, human understanding nurtured by compassion and generous concern for others is the best formula.

Catholic Health Care

The Catholic Community has been one of the major architects of U.S. health care. Early in the nation's history, religious orders of women and men responded to the plights of myriad communities. Sisters of Mercy responded to those devastated by the smallpox epidemic; those overwhelmed by the effects of "incurable cancer" were tended by the Dominican Sisters of the Sick Poor; and the miners and loggers of the Northwest received care from the Sisters of Providence. The ministries they established have become ministries of the whole church, being shaped by—*and shaping*—social, political, and economic forces.

Today, highly complex and sophisticated institutions are most often the face of Catholic health care. The Catholic Health Association affirms, "The mission of Catholic health care is to continue the healing ministry of Jesus by serving the health needs of individuals and communities, especially those who are poor and vulnerable…only institutions can marshal the technical resources and professional skills of significant numbers of people... [embodying] the values that transform services into a ministry of the Church."[4]

Our commitment to the ministry of health and healing has taken us, throughout history, into homes, institutions, board rooms, and before legislative bodies. Convinced of the truth of Martin Marty's insight that "A moral society is perpetually unfinished—all questions have not been answered, but all questions continue to be asked," we are called to do no less today.

1 *A Sign of Hope*, October 18, 1995

2 *Declaration on Euthanasia*, Sacred Congregation for Doctrine of the Faith, 5 May 1980, I

3 *Declaration on Euthanasia*, Vatican Congregation for Doctrine of the Faith, 5 May 1980, IV

4 Catholic Health Association, *Toward A Theology of Health Care Sponsorship*, Facilitators Guide, 2004; p. 18

Mercy in the Valley

Mirna Ramos-Diaz, M.D.

Mirna Ramos-Diaz, M.D. is a pediatrician in Toppenish, Washington.

God whispers in our pleasures but shouts in our pain.
—C.S. Lewis

People who are poor face numerous obstacles in accessing medical care. As a pediatrician caring for and ministering to migrant workers in Eastern Washington, I witness people dealing with immense barriers such as color, legal status, and lack of education. Women and children of color do not blend into the dominant culture. They are looked upon as different and are subject to prejudices that range from lack of simple courtesy to decreased expectations in school. Startling is the degree to which poverty and discrimination contribute to poor health.

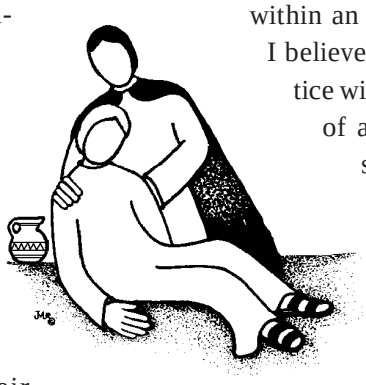
Access

Access to health care is the primary problem in the community where I practice. Undocumented women do not have full access to medical coverage unless they are pregnant. Our clinic offers sliding fee scale based on a person's income. In order to be eligible to receive basic health insurance, a person must have an income 200% below the federal poverty level. Even then, the waiting period to be accepted is three to four months.

Basic Health Insurance of Washington covers office visits, emergency room, inpatient hospitalization, ambulance, and prescription medications. However, this plan generally does not cover routine opthalmological exams, eye glasses, orthoptic therapy, speech therapy, neurodevelopmental therapy, hearing aides, and obesity treatment, to name a few services. We have a population of children who regularly needs these services.

The waiting period for treatment of pre-existing conditions is nine months. Difficult-to-obtain emergency coupons may be used for life threatening pre-existing conditions; yet oftentimes, providers and clinic personnel must write numerous letters to various agencies before a patient is approved for emergency coupons. I have had more than one case where a child with a condition as severe and acute as leukemia or congenital heart disease was denied care because they were undocumented and came to this country with the disease already diagnosed.

Fear of deportation keeps many of my clients away from the clinic during times when immigration officials are known to be present in the community. Many do not apply for health care due to fear of being taken away from their children and families. They are often unaware of their legal rights as undocumented persons. These are women and men who work daily in the fields and packing warehouses.



Lack of education compounds an immigrant's ability to navigate through a complex system so foreign to them. Many come without having completed their formal primary education and without a GED equivalency. Still others do not know how to read or write in English and some are also illiterate in their native languages.

Hope in the Valley

Is there hope in our Valley for a system of health care that embraces all of God's children? As a late-comer to the Valley, I see men and women working through the legislative process to forge new ways of expanding care to those who work so hard to bring fruits, vegetables, and wines to our dinner tables. I see nurses, teachers, physicians, pastors, and women religious ministering countless hours to their neighbors in this Valley community; providing services not only in the healing ministry, but also in the teaching ministry.

Compassionate, community-based care is the cornerstone to creating a society of justice for all people. As a physician working within an immigrant community, I believe that our pursuit of justice will lead us to the creation of a universal health care system, where everyone has equal access to equal quality care.

When Jesus was asked, "And who is my neighbor?" (Luke 10:29), He told the Parable of the Good Samaritan and offered a radical re-imagining of who it is we are to care for and how. When all others passed by the wounded man on the road to Jericho, the Good Samaritan stopped and showed mercy. Jesus asked us to go and do likewise. Those who are poor and vulnerable, immigrant women and children, the sick who are denied health care in this nation of riches…these are our neighbors. We are called as a nation to show mercy.

Steve Brennan is Director of Public Policy and Regulatory Affairs at Providence Health System in Seattle.

Anatomy of a Storm

Steve Brennan

The bestselling book and movie, *The Perfect Storm*[1], describes an extraordinary event in nature in which three unrelated storms merged to create something far more destructive than each might have on its own. Health policy experts are warning of circumstances that could produce a period for our health care system that draws a strong analogy to *The Perfect Storm*: Problems that by themselves might be solved carry the potential to cause catastrophic results when they combine and interact with each other.

The following problems can be considered as individual "storms" gradually worsening:

1. As many as 45 million Americans are without health insurance and still more are "under-insured," struggling to keep up with double-digit cost increases;

2. Drug costs have grown at roughly 15 percent over the past few years. It is expected that the Medicare Modernization Act will fuel utilization of various prescription drugs, adding to drug costs' share of health care spending;

3. Physician and hospital liability insurance costs have skyrocketed in some areas, particularly for physicians who practice high-risk specialties such as neurosurgery and obstetrics. Political gridlock has prevented government from offering a solution to the liability crisis;

4. The federal budget deficit is higher than it has ever been and is projected to reach as high as $5 trillion in ten years;

5. Most state budgets are also in bad shape, unable to adequately meet the demands of their social and health care programs;

6. The Medicare program is projected to be insolvent by 2019—just as the large baby boom cohort is felt most;

7. The hostile and negative environment of partisan posturing due to presidential and congressional campaigns in 2004 is not expected to moderate much in 2005. It is expected that reforms will be proposed to reduce the federal government's responsibility for Medicaid and the State Children's Health Insurance Program (SCHIP).

When these issues are placed against a backdrop of starkly differing views on how they ought to be addressed, the result is a particularly volatile situation for hospitals and other health care providers. As a result, efforts began on Capitol Hill in 2003 to re-focus the debate away from whether or not universal health insurance coverage and access to care are attainable to targeting certain segments of the health care system as sources to blame for the current problems:

- Several Congressional hearings on Capitol Hill in 2004 focused on the high costs of health care, hospital charging and collection practices, and not-for-profit health care providers;
- Bills that would mandate that hospitals discount charges to patients below a specified income level were introduced and debated in several state legislatures;
- There is considerable speculation among Congressional staff and policy analysts that Congress will seek to rein in Medicare costs through legislation similar to the 1997 Balanced Budget Act, which eliminated deficits by cutting more than $300 billion in Medicare payments to doctors, hospitals, nursing homes, and other providers;
- Physicians are facing as much as a five percent reduction in their Medicare reimbursement beginning in 2006 as a result of a payment formula linked to the Gross Domestic Product (GDP). In order to preserve access to physicians, it is expected that Congress will seek to reduce payment to other providers to cover the increased cost;
- Members of Congress are expected to debate whether to significantly cut Medicaid funding for 2006 (A proposed cut of $2.2 billion was voted down in 2004).

"Political gridlock has prevented government from offering a solution to the liability crisis."

How is this likely to unfold in 2005?

With a strengthened majority in Congress, Republicans will continue to advance a broad health

care agenda that seeks to shift responsibility for health care to the individual, rather than the collective, e.g., government. Health Savings Accounts or 'HSAs' are a defined contribution approach to health coverage whereby an employer or individual (and, if the GOP is ultimately successful, the federal government) provides a set amount of tax-deferred money into an account that is used to pay for health insurance, usually in the form of a catastrophic-coverage plan. Individuals would then be fully responsible for managing their own health care, particularly preventive and primary care services. The most recent nomenclature for this concept is "Consumer-driven Health Care."

It is unclear how successful this model of coverage will be from the societal perspective. Proponents argue that it will ultimately create a more efficient health care system because patients will be informed consumers of their care. Critics argue that many people will find themselves unable to afford the high deductibles associated with HSAs and that this will lead to greater levels of bad debt and uncompensated care carried by hospitals and other providers. Moreover, critics contend that HSAs will attract healthier enrollees, in turn increasing the cost of health insurance for those people who incur high costs due to a chronic disease or other long term health condition.

The present environment could be exacerbated by political gridlock in government and protectionism among the various segments of the health care system. Catholic health systems in the Northwest and the Catholic Health Association are bracing for this "perfect storm" by reminding policymakers that not-for-profit, mission-based health care is a key element of the health care safety net and efforts that further weaken local hospitals will harm the already stressed network of care for those who are uninsured.

1 *The Perfect Storm: A True Story of Men Against the Sea* by Sebastian Junger.

WANTED: VOLUNTEER PHYSICIANS AND PEOPLE WHO NEED DOCTORS

Inspired by a successful model in South Carolina, the *Volunteers in Medicine Clinic* of Eugene, Oregon matches retired physicians and other willing practitioners with the health care needs of the community's working poor.[1] It provides low-cost health care in addition to an on-site dispensary where patients can have prescriptions filled at little or no cost. Among their many supporters are Peacehealth and the Sisters of St. Joseph of Peace.

While a core group of paid staff ensures administrative and medical continuity, the clinic relies heavily on 60 primary care physicians and nurse practitioners, in addition to 250 specialty care providers, who volunteer their time at the clinic or in their own private practices.

The clinic is funded by individual donors and foundations, and leases its building from Peacehealth for $12.00 a year.

Established in 2001 to provide affordable *primary* care to the uninsured, the clinic has since developed education and disease management programs specifically for diabetes and mental health—two of the main reasons people come to the clinic.

"The cost of diabetes is very high because of the supplies and medicines needed to control it and because it affects many body systems," explained Executive Director Sister Monica Heeran.

"Many of those seen at the clinic have not been treated by a physician in years," she said. "Our volunteer practitioners give generously of their time and talent. At the *Volunteers in Medicine Clinic*, lives are saved and worlds are changed—everyday!"

[1] People earning 100 to 200 percent of the Federal Poverty Level

Consider a one-time gathering of currently practicing and retired physicians in your church to reflect on the healthcare needs of the underserved in your community. How might you use your talents and resources to creatively address some of these needs?

Jeff Huebner, M.D., is a family physician at Harborview Medical Center and a member of St. Joseph's Parish in Seattle. He is on the Board of the Universal Health Care Action Network.

Prescription for Reform

Jeff Huebner, M.D.

health care is an essential safeguard of human life and dignity and therefore [it] is an obligation for society to ensure that every person be able to realize this right.

ó Cardinal Joseph Bernardin

Ms. Z is one of my favorite patients. Perhaps it's because she always smiles and never complains, even though I know she has much to complain about. Perhaps it's because I know she is doing all she can to take care of herself and her family: working, going to school, and raising two children. During appointments her children are always playful, yet polite and well-behaved. Looking at them, I sense I am looking into the smile of God.

At first glance you would never know the hardships faced by Ms. Z and her family. She has type 2 diabetes, the type that usually develops in the later stages of life. When I first met her in my clinic, the disease had already advanced to the point where she needed insulin shots and had trouble with her feet. She had recognized some of the symptoms years ago, but did not see a doctor because she has no health insurance. Still, to this day, she sometimes skips medications because she cannot afford them. I know things must change, or she might die before seeing her children graduate from high school. I joyfully return their smiles, but go home saddened and angry that our society does not do better to support this family.

The Problem of Access to Care in the USA

This story reflects the plights of nearly 45 million Americans and 750,000 Washingtonians without health insurance. During the recent presidential campaign, you may have heard President George Bush say that we have the best medical system in the world. Certainly, we have the highest-priced health care in the world (now more than $1.5 trillion annually). And if you walk into a local hospital you will likely find the most-advanced medical technology. But what do we get for the money?

According to a recent World Health Organization report, our health care system does not even rank in the top twenty in the world. Life expectancy rates are lower than those of many other industrialized nations and infant mortality rates are higher at 6.75 infant deaths for every 1,000 births.

Can We Afford Universal Health Care?

First, we should consider the costs of our current fragmented system of health care. We pay approximately twice the money for our system—over $5,000 per capita and nearly 15% of GDP—compared to the next most expensive system in Germany. In 2005, Premiums for health insurance for a family of four are expected to top $10,000.

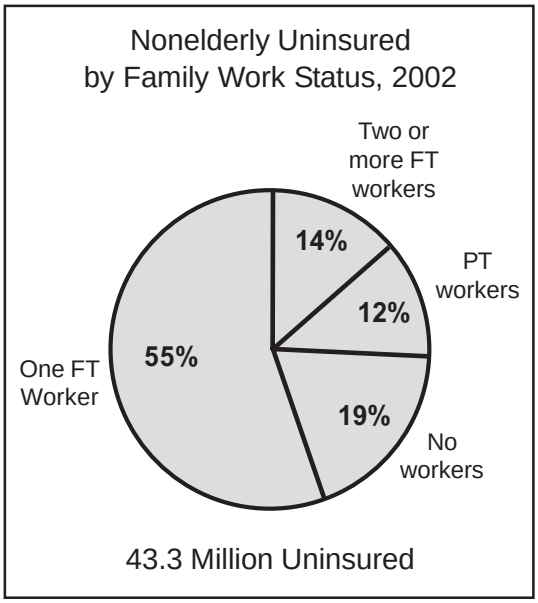
"Our health care system does not even rank in the top 20 in the world."

Why does our system cost so much? A recent study of the *New England Journal of Medicine* reported that overhead and administrative costs in the U.S. are double those of Canada, a 'single-payer' system. Doctors' offices often must hire multiple employees simply to process claims. In Seattle, for example, there are 700 different health care plans.

While innovative medical technologies provide new options for care, they similarly contribute to increased costs. We historically have been unwilling to grapple with the notion of "rationing," so you see every hospital that survives continually expanding with "new" MRI scanners, cardiac suites, and neonatal intensive care units. Because we have no regulation of drug prices and direct-to-consumer advertising is rampant, prescription drug prices are the highest in the world.

By most accounts, universal health care would actually be cheaper for our country, regardless of the model we picked. Analysts believe that $300 billion could be saved annually by streamlining administrative costs if we moved to a "single-payer, Medicare-for-all" system. Although the absolute costs projected in news reports often sound steep because taxes would increase, both businesses and citizens would pay less in taxes for their care than they pay now in the form of taxes, premiums, and co-payments combined.

Many analysts argue that we cannot afford NOT to have universal health care. The leading cause of bankruptcy in the U.S. is health care bills. The prospects of large bills keep many people at home when they should go to the doctor, leading to delayed diagnoses of treatable and oftentimes preventable illnesses such as diabetes



Kaiser Commission on Medicaid and the Uninsured/ Urban Institute 2003

and cancer. This, in turn, leads to increased costs to individuals in terms of their health and quality of life; and to society in the form of higher expenditures for preventable hospitalizations and ER visits.

Options for Reform: How Our Neighbors Do It

The U.S. is the only industrialized country in the world that does not guarantee health care for all of its citizens. Other nations generally use one of three different models:

1. Single-payer: Publicly financed national health insurance with private practice physicians and hospitals, e.g., Canada, Sweden.

2. National health service: Public hospitals and salaried physicians, e.g., Great Britain, Spain, Cuba.

3. Multi-payer: Combination of public and private health insurance systems where people can access some care through private insurance or choose full private insurance if they wish, e.g., Germany and France.

Principles for Health Care Reform

The Institute of Medicine recently recommended that the U.S. adopt some form of universal health care by 2010. While it did not prescribe a certain system, it recommended these principles to guide reform. Health care coverage should be (1) universal, (2) continuous, (3) affordable to individuals and families, and (4) accessible. The nation's health care system should enhance health and well-being by promoting access to high quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

Single-payer activist physician Dr. Quentin Young sums it up directly when he says, "Everybody In, Nobody Out." Clearly, a model similar to Canada's provides the most egalitarian form of health care, whereby all citizens have access to equal and high-quality health care. That is evidenced by our popular version, the Medicare system, which has shortcomings—most notably prescription drug coverage—but has given the nation's seniors improved health and financial security since its enactment in 1965.

There is no doubt that a nation as wealthy as ours can successfully engineer a progressive compromise version of health care reform that incorporates the best of what U.S. and universal systems have to offer, if only we have the political will.

COMPASSIONATE CARE IN HARD TIMES

"Mental health services are not being funded," stated Susan Hammond, Director of Psychiatric Services at Sacred Heart Medical Center, Providence Health Care in Spokane.

Sacred Heart's mission is to provide compassionate care to all people regardless of their ability to pay. As the only community hospital in Eastern Washington providing full service acute psychiatric care, it struggles to embody its mission. Sacred Heart's services include emergency room triage and three in-patient psychiatric units for children and adolescents, adults, and geriatric patients.

Eighty percent of the mental health patients treated at Sacred Heart are unable to cover the cost of their care. This leaves the hospital to cover a significant portion of the cost of treatment.

"These people cannot afford less intensive intervention, such as counseling, in their communities," explained Ms. Hammond. "The only treatment option that the uninsured and indigent can access is the hospital, which is the most expensive option."

Ms. Hammond does point to some hope. The mental health legislative task force appointed by Governor Locke is scheduled to report back with proposed solutions; the Mental Health Parity Bill may have a better chance of passing through the Washington State Legislature in 2005; and one legislative package proposes funding of non-Medicaid-eligible low income patients at the Medicaid level. Such measures would help ease the stress on Sacred Heart but, as Susan Hammond reminds us, even Medicaid and Medicare reimbursement rates are inadequate to cover the rising costs of treatment and care.

Communicate with your state and national legislators about the need for increased mental health funding. Ask them to support the Mental Health Parity Bill that would ensure equal access and reimbursement for mental health services.

Dianna Kielian is Vice President of Mission for Franciscan Health System.

Catalyst for Healing

Dianna Kielian

Most of us count on some real constants in our lives—such as having a job and good health," explained Janice Poole, the first client of the Lakewood Community Dental Van. "But, all that can change in a blink of an eye."

A layoff from her previous employer turned Janice's world upside down five years ago. Not only did she face the challenges of unemployment, she was a single parent with two teenage daughters and she was in the midst of a second battle against cancer.

Janice immediately found herself in desperate need of oral health services. The cancer treatments were causing deterioration of her jaw and teeth bone structure. Now uninsured, she had to search for a dentist who would provide charity care or a sliding fee. After numerous phone calls, she learned of St. Clare's Dental Van, a service provided within the community of Lakewood through a partnership with Northwest Medical Teams International, Clover Park School District, and Franciscan Health System (FHS).

Dentist and assistant at work

Janice's oral health needs required several visits to the van, resulting in over $4000 of in-kind services. Overwhelmed with gratitude for the services received, she felt compelled to give back. Janice volunteered at St. Clare Hospital several days a week and was quickly hired as the Volunteer Coordinator. For three years Janice recruited volunteers not only for the Dental Van, but also for many other departments within the hospital. Janice's story illustrates how compassionate health care can be a catalyst for personal transformation.

Lakewood Community Dental Van

"Janice's story illustrates how compassionate health care can be a catalyst for personal transformation."

In 2002, Janice died of cancer. She inspired all of us who met her at St. Clare Hospital. Her story is one of many of the adults and children served through the St. Clare's Dental Van. Since the first day when Janice walked into the dental van, the van has provided over $400,000 of in-kind oral health services to more than 1000 adults and children in the Lakewood community.

To create healthier communities, the health system believes in being in the community, co-creating with others. In 1981, the Bishops' *Pastoral on Health Care* called the health care community to work "to restore health and wholeness in all facets of the human person and the human community." The *Religious and Ethical Directives for Catholic Health Care* direct us to build healthy communities as part of our Catholic identity and to practice the principle of the common good through promoting the health of all in the community.

We take our responsibility of being a good community citizen seriously. Whether it is working in local churches to establish a parish nurse program, partnering with public health and local youth groups on tobacco prevention, or participating in community coalitions, FHS is committed to collaborating with others.

Affirmed by our Mission, we seek to emphasize human dignity and social justice as we encounter courageous people like Janice Poole. It is our fidelity to the Gospel that calls us toward the creation of healthier communities.

Private and Universal Health Care: Two Perspectives

	Private	Universal
Definitions:	Largely employer-based and consumer driven in the free-market, involving private insurers and Health Maintenance Organizations (HMOs) • Financed, in part, through co-pays, premiums, deductibles, & other out-of-pocket spending.	'Single-payer' is one form of health care where costs are paid by one institution, i.e., the government. • Financed, in part, through taxes. • Canada & Sweden have single-payer systems. • The U.S. Centers for Medicare and Medicaid Services (CMS) is single-payer.
Access:	45 million Americans do not have health insurance & forgo seeking care for treatable & preventable diseases.	Everyone has a "health care home", i.e., a family physician who can refer out for specialty care.
Wait Time	Varies greatly depending on a person's health insurance status and ability to pay. For example, the poor often wait hours/days/weeks to be seen in overburdened neighborhood clinics. More affluent people can afford personalized 'concierge care.'	All people have access to their family physician. Wait times for specialty care can be up to two months. Wait times for acute care can increase during epidemics.
Rationing	Usually based on the cost of treatment and medication. HMOs work with insurers to determine who can receive what treatment. People who cannot afford medical services or insurance often go without care.	Rationing is based on medical necessity determined by physicians, patients, and national regulations.
Pre-Existing Conditions	Most insurers require a waiting period before covering treatment for pre-existing conditions. Undocumented immigrant children can have difficulty obtaining care for pre-existing diseases.	No one is denied care due to pre-existing conditions.
Cost of Prescription Drugs	Out-of-pocket spending on prescription drugs rose to $48.6 billion and exceeds the amount Americans spend on hospitals, dentists, and nursing homes.[1] Private insurers and providers have formularies that determine which medications are covered, often influenced by cost. The uninsured frequently go without needed medications.	Everyone has prescription drug coverage. The single-payer system has a formulary based on medical necessity. Under universal health care, prescription drug costs can be regulated and the price significantly reduced through the government's massive buying power.
Administrative Costs[2]	In 1999, administrative costs for the private U.S. system totaled $1,059 per capita and comprised 31% of the total U.S. health care spending.[3]	Administrative health care costs in Canada totaled $307 per capita.[4] When compared to administrative costs in the U.S., Germany's costs represent 68% of U.S. costs, Netherland's 45%, and Canada's 15%.[5]
General Health	People who lack health insurance die at an earlier age of preventable and treatable diseases such as diabetes, hypertension, and cervical and breast cancers. Life expectancy in the U.S. is 79.3 years.[6] The U.S.'s infant mortality rate ranks 35th in the world with 6.75 deaths per 1,000 live births.	Preventive care minimizes expensive care associated with undetected, untreated health problems.[7] Life expectancy rates are higher in industrialized countries offering universal health care: 80.8 years in Sweden and France.[8] Japan's infant mortality rate ranks 1st in the world with 3.30 deaths per 1,000 live births (half the U.S. deaths), Sweden's ranks 2nd with 3.42 deaths.

1 Network Connection, March/April 2004
2 Planning, regulating, & administering costs incurred by health insurers, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, & home care agencies
3 Harvard Medical School and the Public Citizen Health Research Group
4 "Costs of Health Care Administration in the United States and Canada." Drs. Woolhandler, Campbell, and Himmelstein
5 "Administrative Costs in Selected Industrialized Countries: Special Report" Jean-Pierre Poullier
6 "Demographic, Comparative, and Differential Aging." http://mcb.berkeley.edu/courses/mcb135k/lect1.html
7 "Canada's Single Payer Health Care System – It's Worth a Look." Bruce Robinson
8 "Demographic, Comparative, and Differential Aging." http://mcb.berkeley.edu/courses/mcb135k/lect1.html

Faithful Citizens

IPJC provided 23 workshops on faithful citizenship this fall. A diverse group of participants in Washington and Oregon engaged in education, reflection, dialogue, and action in relationship to the Catholic Social Teachings.

Participants dialogue on political issues

We need your support—prayers and contributions

- A donation of any kind makes a difference to us!
- If your company matches, that will double the difference!

A special thank you to the 496 of you who have supported us with a donation in the last year. That represents 11% of the 4,600 households receiving *A Matter of Spirit.*

Sunnyside Justice Circle participants

To Everything There is a Season

In the Book of Ecclesiastes we read, "There is an appointed time for everything." In the fall and winter shareholders have the opportunity to file shareholder resolutions with corporations. Our goal is to use our power as shareholders to shape a more just world. During the 2004-2005 shareholder season, Northwest Coalition for Responsible Investment members are addressing corporations on the following issues:

- HIV/AIDS
- human rights
- violent video games
- U.S. pharmaceuticals
- elimination of the depiction of smoking in movies
- labor standards
- global warming
- genetic engineering
- corporate governance

Our immediate goal in filing shareholder resolutions is twofold:

- bring the justice issue to the attention of the company's shareholders
- move the company to dialogue with us.

At this time we have dialogues scheduled with:

- PepsiCo and Pfizer on HIV/AIDS
- Sears on implementing & monitoring its Buying Policy
- ChevronTexaco on global warming & human rights
- Dow Chemical on genetically engineered seed
- Time Warner on the depiction of smoking in movies and teen smoking

The NWCRI 2004 Annual Report is available at www.ipjc.org, or 206.223.1138

Women's Justice Circles Flourish in Rural Washington

Three of the Fall Justice Circles are dealing with issues that affect Spanish speaking low-income and immigrant women:

Mattawa—The Women's Justice Circle organized a presentation to the city council related to domestic violence response time by the Mattawa Police Dept. The mayor scheduled a meeting of the police chief, county sheriff's office, and the Justice Circle.

Sunnyside—The Women's Justice Circle has continued into its second year and is now a Parent's Justice Circle addressing the needs of Spanish speaking students and the Washington Assessment of Student Learning (WASL). The Justice Circle has been successful in meeting with state representatives and influencing the Sunnyside School Board to seek alternative solutions to testing.

Wapato—The women of Wapato are holding their third Women's Justice Circle with new leadership that is guiding the Circle in addressing the issues of housing maintenance programs provided to those who are low-income. A Representative from a federally funded program will meet with the Justice Circle later this month to assist them.

Northwest Catholic Women's Convocation III

April 22-23, 2005

Registrations are coming in fast!

If you are on our **women's programming** list, brochures should arrive in the mail in the second week of January. Be sure to sign up early and reserve your spot for the Convocation at the Washington State Convention and Trade Center.

Cost: Early registration is $95 (Scholarships available). After March 1st the cost will be $120.

Call/Email: IPJC at 206.223.1138 or convocation@ipjc.org for a registration brochure.

Website: You can view the registration brochure information online and then print out the registration form to send in.

***Uprising of Hope* Pre-Convocation Gatherings**
Call IPJC if you can convene a small women's winter gathering in your home or parish to reflect on the theme of *Uprising of Hope*, share prayer, provide brochures, and encourage women to join 2000 other women April 22-23rd for the Convocation.

Young Adult Interfaith Justice Series

- Learn from and Listen to Muslim, Jewish, and Buddhist wisdom
- Explore faith traditions from a justice perspective
- Discuss and Dialogue about ways to build bridges across faith traditions
- Experience prayer and reflection with others
- Enjoy good food and refreshments

Our First event in the series with Jamal Rahman, a Muslim Sufi minister, provided a rich experience of the interface of justice and compassion in Christianity and Islam.

Come Join Us for An Evening of Education, Reflection, Dialogue & Community Building

Tuesday, February 1, 2005
Judaism and Justice
Rabbi Zari Weiss
7:00 pm— 9:00 pm

Tuesday, May 3, 2005
Mahayana Buddhism and Justice
Rev. Genjo Osho-San
7:00 pm— 9:00 pm

The series is sponsored by the Intercommunity Peace and Justice Center and hosted by the School of Theology and Ministry at Seattle University in the McGoldrick Commons Room of Hunthausen Hall. For more information, or if you would like to help with the series, call us at 223-1138 or email us at ipjc@ipjc.org.

Church Advocacy Days

Elections are over, but now the work of monitoring and mentoring our elected officials begins. Please join us for an opportunity to advocate on behalf of the most vulnerable.

Church Advocacy Days at the Capital

Olympia
Thursday, February 24, 2005

Salem
Monday, February 21, 2005

If you are unable to join us in meeting your legislators at the Capital, please join at one of the following:

Legislative Briefing Days

Spokane—Saturday, January 22, 2005, 9 am to 2 pm, Unitarian Universalist Church

Yakima—Saturday, February 12, 2005, 9 am to 12 pm, United Christian Church

Tacoma—Thursday, January 27, 2005, 7 to 9 pm, First Christian Church

Seattle—Saturday, February 5, 2005, 8:30 am to 12:30 pm, St. John Lutheran Church


Young adults discuss with Jamal Rahman

Health Care Resources

American Medical Student Association
www.amsa.org

Catholic Health Association
www.chausa.org

Center for Medicare and Medicaid's "An Overview of the U.S. Healthcare System: 1980-2000."
www.cms.hhs.gov/charts/healthcaresystem/chapter1.asp

Ethnomed: Ethnic medicine information from Harborview Medical Center
http://ethnomed.org/ethnomed/immigration

Everybody In, Nobody Out (EINO)
www.everybodyinnobodyout.org

Families USA
www.familiesusa.org

Health Care Crisis – PBS
www.pbs.org/healthcarecrisis

National Coalition for the Homeless
www.nationalhomeless.org/universalhealth.html

Physicians for a National Health Program
www.pnhp.org

Universal Health Care Action Network
www.uhcan.org

YOUTH MENTORS, MATCHING MONEY

Unwilling to ignore increasing rates of drug use, teenage pregnancy, and high school incompletion, St. John's Hospital/Peacehealth in Longview collaborated with local high schools to initiate the Youth Mentorship Program. This employment and training program supports high school students who have been identified as being at increased risk for dropping out of school.

The hospital hires the student part-time and assigns a one-on-one employee mentor to train the student. The mentor offers encouragement so that the student has a better chance of finishing high school and going on for further education. The student puts aside one-third of their salary to be used for education. St. John's matches the savings in the form of a scholarship to the school of the student's choice.

"Our Mission calls us to use our resources positively in response to the needs of our community, especially in regard to the poor and underserved," said Sister Rose Marie Nigro, CSJP. In today's bureaucracy of profit-centered healthcare, this holistic commitment to community health is a unique beacon of light raising up the common good and dignity of all.

As a parish, community, or family what creative ideas can you identify to support teens? With whom might you create a collaborative partnership?

***A Matter of Spirit* is a publication of the Intercommunity Peace & Justice Center**

SPONSORING COMMUNITIES

Adrian Dominican Sisters

Oregon Province Jesuits

Sisters of the Holy Names of Jesus and Mary, Washington Province

Sisters of Providence, Mother Joseph Province

Sisters of St Francis of Philadelphia

Sisters of St Joseph of Peace, Western Province

Tacoma Dominicans

AFFILIATE COMMUNITIES

Benedictine Sisters of Cottonwood, Idaho

Benedictine Sisters of Lacey

Benedictine Sisters of Mt. Angel

Religious of the Sacred Heart

Sinsinawa Dominicans

Sisters of Charity of the Blessed Virgin Mary

Sisters of the Holy Names of Jesus and Mary of Oregon

Sisters of St. Mary of Oregon

Ursuline Sisters of the Roman Union

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