Ethical Issues in Medical Insurance

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An attempt was made in residency to teach me that the economics of medical practice mattered a great deal. I disregarded the effort, mostly out of a sense that my primary priority ought to be mastery of facts about diseases and treatments. In addition, it was easy to disdain monetary concerns coming from a group of physicians who seemed comfortably fixed with fine homes, second homes, expensive clothes, hobbies and automobiles. It seemed that they were speaking of "looking out for number one" financially, and some of them were. Less than a year out of residency, I discovered that some of my teachers had been referring to other powerful influences upon medical practice that attention to their own incomes.

The practice I was in was rural and heavily Medicaid. The "Aha!" experience, when the light dawned on me regarding the influence of the financing of medical care, began after I had examined two patients in succession from the same family. Each had a complaint which usually is not accompanied by physical findings or helpful laboratory tests. I don't recall now what the complaints were, but they were of the nature of an occasionally recurring tension headache. In a third examination room, I discovered yet a third patient from the same household. This time, there was an unmistakably ill patient, who had physical findings (fever, productive cough, rales, elevated WBC) and a story that matched the findings. After dealing with that patient, I found a fourth room to contain yet another member of the same household who had complaints with no physical finding to match. The complaints sounded like a viral upper respiratory infection which could be expected to be self-limited in this otherwise healthy young person. All four of the patients were Medicaid.

When realization struck as to what had probably occurred, I decided to chick it our. I voiced my suspicions to a Navy-veteran medical assistant who had known the family for years. He laughed at my naivete and suggested asking within the family. the matriarchal head of the household was not one of the four patients, but was present and answered my delicately phrased question: I understood why the patient with pneumonia had come, but was puzzled as to the reasons why the other three had come, since they did not seem very ill. Without hesitancy or embarrassment, she explained that the trip was occasioned by the ill patient. Since they were coming to the doctor anyway, she had thought it a good idea to have the others "checked".

Of the three whose illness was determined only on the basis of their history, two had already left the office with a prescription

given by me, based upon their symptoms. Given the risk of any medication, they were probably more at risk from having come to the doctor than if they had stayed home! Behavior of this sort was alien to me. Even if a doctor visit had cost me nothing, as it had these four, I had always had better things to do than sit in a doctor's office to be examined. Unfortunately, with many variations on the theme, this sort of episode occurs regularly in American medicine. IT is exceedingly costly. The Medicaid system paid the same amount for my service to the patient with pneumonia as for the three who would have recovered had they never come, if indeed they were ill to begin with. In the one case of the patient with pneumonia, I was underpaid for the value of the service rendered. In the other three cases I was underpaid for the time spent with them, but grossly overpaid for the service rendered, since it was either of little worth or actually hazardous to them.

Though part of the fault lay with my naivete in not considering the family as a whole, part lay with the family's lack of financial restraint in seeking medical care. I have since tried to mend my practices, though certainly I am not able to catch all such visits, classified a "opportunity visits". The notion of restraining anyone's access to medical access to medical care by financial considerations is usually presented as a problem to be solved. As this example demonstrates, lack of financial restraint can cause medical problems, as well as unnecessary expense. The effectiveness of medical care tends to be overrated, while the hazards of medical treatment tend to be underrated. For this reason I am convinced that, in our current situation, lack of access to medical care due to lack of money is no more problematic than is lack of financial restraint in seeking medical attention. Inability to obtain wanted medical care is commonly lamented without any recognition that broadening access without restraint may also be cause for lament.

It is inevitable that we must pay to sift an increased number of not-very-ill patients presenting because of Medicaid and other insurance plans, possibly putting them at risk, in order to find the one in whom medical care will make a positive difference? Are occurrences of this sore an irreducible characteristic primary care medicine, or are they related to the insurance scheme? A clue came when I noted later that self-pay patients almost never seemed to behave in such a fashion. Moreover, their health did not seem to be any worse than those for whom insurance coverage, of one sore or another, reduced barriers to a medical encounter.

For a while, I developed a positive hatred of all medical insurance, and invested it with a large share of blame for what ails American medicine. Many bible passages, however, strongly support the idea of insurance as a good idea. Proverbs 27:12 states, "The prudent see danger and take refuge, but the simple keep going and suffer for it." Though we cannot predict it in detail, illness is virtually certain to strike each of us at some time in our life. Medical insurance can provide a kind of refuge, if we are willing to foresee probable illness. Provision for the foreseeable future is also

counseled in Proverbs 30:25. "Ants are the creatures of little strength, yet they store up their food in the summer." The arrival of the seasons is more predictable than the arrival of illness, but the two are comparable. Proverbs 6:6 commends us to "Go to the ant, you sluggard; consider its ways and be wise! It has no commander, no overseer or ruler, yet it stores its provisions in summer and gathers its food at harvest." Our responsibility to provide for our household is explicit in I Tim. 5:8: "But if any provide not for his own, and specially for those of his own house, he hath denied the faith and is worse than an infidel." It is reasonable to include medical care among the expected provision. John 19:26,27 records Jesus' provision for His mother.

Medical care cannot easily be stored by individuals, but participation in an insurance program can perform the same function; one is "storing" a fund to be expended on anticipated future services. Proverbs 21:20 states: "In the house of the wise are stores of choice food and oil, but a foolish man devours all he has." Clearly, something can be set aside for future exigencies, rather than devoured foolishly. Would it be wise for me to spend surplus money on a classy sports car when I have failed to store something for medical care for my household and for theirs?

John Calvin did not mention insurance in his passage on the eighth commandment (thou shalt not steal) but did summarize the fullness of the teaching of this commandment in both its positive and negative aspects. As part of the positive aspect of the commandment he states, "...let [each man] pay his debts faithfully."[1] Medical insurance is one means of being ready to pay for the debts that illness or injury may suddenly cause.

In summary, it is fair to state that the Bible commends foresight. We can foresee probable medical trouble in general, and insurance enables us to deal with it financially in detail.

Insurance,m not just medical insurance, has certain advantages of economy. If I have insurance I do not have to maintain a fund adequate to replace necessary housing or other property, should it be destroyed. It can share my small risk with others and use the money freed for more profitable investments. Insurance plans can help avoid slavery to enormous debts for which we are liable. Certain Old Testament passages make clear our financial liability for damage which was careless or foreseeable. Exodus 22:6, for example, warns: "If a fire breaks out and spreads into thorn bushes so that it burns shocks of grain or standing grain or the whole field, the one who started the fire must make restitution." A physician might cause more economic damage by careless use of his prescription pad than h would have personal resources to cover. Liability insurance enables us better to compensate anyone we have so damaged. (I will pass over negative aspects of liability insurance).

Because medical insurance is used to pay for medical care, it is often confused with biblical passages commending charity and compassionate acts.

Medical insurance must be clearly distinguished from charity. Charity includes the following features which are absent in insurance:

1. Charity is giving to a specific known need, already existing. IT is not a financial hedge entrusted to others because they might need it. (1 John 3:17: "if anyone has material possessions and sees his brother in need but has no pit on him, how can the love of God by in him?")

2. Charity is not a quid pro quo contract. It lacks the contractual accounting so characteristic of medical and other insurance. (Matt. 6:3: "But when you give to the needy, do not let your left hand know what your right hand is doing.")

3. Charity is the wise use of resources belonging to me to meet a need of another person. It is not the idea of the most for me at the least cost (II Cor. 8:1-4,13-15,20-21).

4. Charity is ignorant of any outcasts. there is no in-group (policyholders) and outcasts (non-policy holding Samaritans). This is bet illustrated by the parable of the Good Samaritan (Luke 10:29,30,33,37). by contrast, an insurance company controls its risk and increases its profits by categorically excluding certain high risk groups: the old, smokers, those already chronically ill, those who have been seriously ill in the past, alcoholics, the un-employed. Charity may include meeting needs of any of these. (There is some comparison in that charity biblically begins at home. It, however, doesn't end there. Also, whereas categorical exclusion is not charitable, individual exclusion may be.) The outcasts, e.g., uninsured and underinsured, are part of the perceived problem in our current medical care system. Nationally, we have been trying to meet the needs of such groups by extending to more and more of them categorical entitlement to insurance. "Undeserved" charitable provision for their care will go farther in meeting their need than installing an undeserved entitlement to medical insurance which bypasses needed restraints and participation by the recipient.

MEDICAL INSURANCE IS UNIQUE

Not only must medical insurance be distinguished from charity, it has two special features that require special rules for it to work well. One special feature is the way claim validation and adjusting is managed; the other feature is the fact that the patient is usually not the person who purchases his medical insurance. The two features are a problem individually and their interaction is especially a problem. We will deal with these two unique features in separate sections.

I. Claim Validation and Adjusting

Let us consider some other types of insurance in order to understand how claim validation and adjustment is different for medical insurance. Life insurance requires a death certificate which must show causes and times that fit the policy restrictions. Homeowner's insurance utilizes an adjuster who inspects the damage and is supposed to be knowledgeable about local repair

and replacement costs. In addition, there is a realistic maximum amount written into the policy and certain exclusions, generally for high value items which must be separately insured. Auto collision insurance utilizes multiple garage estimates or a claim adjuster. A limit on coverage is also written into the policy.

Health insurance claims, however, are often valid simply on the claimant's statement. If my patient tells me she has a headache or dysmenorrhea or dizziness or tinnitus or nausea or back pain, neither I nor anyone can gainsay that. Such a patient can continually utilize insurance resources. Sometimes the resources end up being used helpfully, sometimes wastefully, sometimes actually to the patient's physical harm, as in the case of hazardous treatments or diagnostic testing. In this system the patient can persistently act as his or her own claims adjuster.

This feature of being one's own incontrovertible claim adjuster is different from other types of insurance policies have maximum coverage limits written into them, the effect is not the same as with policies to cover property losses. For one thing, the maximum amounts of coverage are usually very high. Utilization and, therefore, expense to the policy, may bear no good relationship to the significance of the illness or the potential efficacy of treatment available. An insured patient with persistent weak spells, or headaches, or abdominal pain for which multiple practitioners in various specialties admittedly have no effective remedy, can expend more insurance money than one for whom major surgery is life-saving. Until high policy limits are reached, there is no one other than the patient to say, "Stop!" When one is in distress, self-governance is extraordinarily uncommon and that one is in danger of dishonoring God by desperate actions (Prov. 30:7-9).

Hope springs eternal in the human breast. For those with chronic or recurrent and inadequately treatable illnesses, such hope combined with insurance policy, becomes expensive. Fear also springs out of the human heart. Allaying fear can become expensive when an insurance policy is present. In a real sense, a fearful people who are well-insured medically, can attempt to purchase with insurance freedom from their slavery to fear of disease and death (Cf. Heb. 2:14,15).

People also occasionally malinger as did David in Philistia. (I Sam. 21:13: So he feigned insanity in their presence; and while he was in their hands he acted like a madman, making marks on the doors of the gate and letting saliva run down his beard.") Primary care physicians also see a fair number of people whose social, economic, marital, or legal problems are transmogrified into a medical problem. Though the physician may suspect early on in the diagnostic process that the problem is basically not medical in nature, the proof of that suspicion is expensive if it is possible at all.

AN HISTORICAL INTERPRETATION

Historically, health insurance was not

common in this nation until after World War II. It began to grow in the early 1950's. The additional money in the health care system stimulated its expansion, as it would any industry. New techniques, higher standards and better hospitals resulted. The prices also went up. Higher prices made the financial threat of illness greater. Health insurance thus became more attractive and more people bought it. Government allowance of insurance premiums as a deductible item encouraged employers to purchase it as a benefit for employees. Some people perceived a contrast between the health care delivery to the insured and to the uninsured elderly and poor. Believing health care to be a right to be secured by government, these people created a political clamor for these lesser-served groups to be included in the health care smorgasbord. They had their way in the mid-1960's.

Medicare and Medicaid were spawned. More money was turned into the industry and it responded with ever more sophisticated therapies, ever higher standards, and higher costs. Ordinarily, supply would keep up with demand, or the price would restrain the demand. However, if someone else is paying most of your health care costs, price is no restraint. Demand for health care is quantitatively unlike other human wants. It is more difficult to saturate.

Suppose, for example, that the government of Lower Slobbovia (with apologies to the late Al Capp) decided that possession of a refrigerator was a basic human right, to be guaranteed by the government. This government realization would come after private efforts had placed refrigerators in the homes of many people, stimulating an increase in refrigerator designs (and price). After a significant fraction of the population was discovered to be without basic refrigerator availability, a government program would be instituted to meet this need. Through government subsidies to manufacturers and other means, refrigerator production would rise. Refrigerator technology would advance rapidly with the new infusion of money. Standards for what constituted a "decent" refrigerator would be drawn up and updated annually, along with prices.

A new government bureau, Humane Cool Food Agency (HCFA), would be set up to enforce Slobbovian refrigerator guidelines. Private advocacy and political groups would be continually finding geographic and demographic pockets of refrigerator deficiency, developing these pockets into new private markets and political constituencies. With such a national effort, and given the fact that refrigerators are completely designed by and understandable to their designers, there would come a time in lower Slobbovia in which you could leave beautiful new, high quality refrigerators on street corners to be taken for free, and no one would bother.

I don't believe you could reach such a saturation point with medical care. Though most people would behave reasonably, there are plenty who would sop up all the resources provided to them, and demand more. Furthermore, unlike refrigerators, the human body was not designed by man,

and is little comprehended by any man. There will be no end to researching the human body.

As medical care has apparently reduced disease, the response in our culture has been to medicalize more and more of life's hazards and problems. We have more medical problems now than 50 years ago, simply because of the expanding definition of what is a medical problem.[2] A popular advice columnist recommends medical treatment for shoplifting. Gambling is considered a disease. Everyone (except God) knows that alcoholism is a disease. Children who squirm and talk too much in school are brought before physicians for cure. Young women who starve and cause themselves to vomit in order to fit our culture's preoccupation with a slender figure are determined to have a disease, a strange disease, unknown in other cultures.

According to Dr. James Maloney,[3] we are reaching an asymptote in the efficacy of medicine to extend life. Each medical gain now is ever so much more costly than the earlier gains. Over the 35 years ending in 1975, average life span increased 15%, whereas per capita expenditures for disease care increased 314%, after correction for inflation.[4] There is an academic dispute as to whether there is an absolute upper limit of life span. The Bible suggests strongly that there is an absolute upper limit of life span. The Bible suggests strongly that there is (Ps. 90:10, Gen. 6:3). You can still read the research either way, but the studies supporting an absolute upper limit seem to me to have the upper hand. We are closing in on that limit. (The much-vaunted increased average life expectancy is severely reduced if all the people aborted since 1973 are counted in the averaging). Future extensions of life will depend more and more on non-medical, behavioral changes. Most youthful deaths in our country are lifestyle-caused: accidents, alcohol cirrhosis, suicide, homicide and, soon AIDS.

The flood of government and insurance money over 30 increased the sophistication and expense of medical care. Simultaneously and out of proportion to the facts, it increased public expectations of medical care. Finally, the bottom of the deep pockets of the insurance companies and government was reached and, having captured much control, they began to turn the screws to govern individuals where individuals refused to govern themselves. The basically good idea of indemnity insurance has been perverted by removal of the governing effects of a free marketplace.

WE NEED GOVERNMENT

Medical care must have a governor. Anyone who governs it will make errors. The best governor is the patient's wallet, the nexus between the values and needs in all aspects of the patient's life. Try a rewrite of the account of the woman with the issue of blood, assuming that she had medical insurance. (Mk 5:25-26: "She had suffered a great deal under the care of many doctors and had spent all she had, yet instead of getting better she grew worse.") Perhaps, if she had access to

modern medical insurance, she would have missed her cure altogether. She might have been off at the Supercalifragilistic Medical Clinic undergoing a fourth PiMeson Scan (at $1,250 a throw).

Governors in medical insurance are the price of the policy and the method of claim validation and adjustment. To determine the method of government, let us examine three common types of third-party payment systems: indemnity insurance and two types of pre-paid insurance.

Indemnity insurance is still a common type of medical insurance. The patient is the claims adjuster; therefore there are not restraints except the deductibles, co-payments and the tenurial hassle of going to a doctor. Co-payments do make a difference. Brooke, et al., reported an extensive experiment in which there was random assignment of about 4,000 people, aged 14-61, none disabled, to one of 14 insurance plans.[5] All of the plans were free in the sense that no premium was required. Only one plan required no co-payment, all the others required incremental degrees of co-payment by the patients for each service they received. The study lasted 7 years.

Patients with no co-payment or deductible made one-third more visits than those with co-payments, achieving only slight demonstrable improvement in health outcome. Several measures were used for health outcome: role functioning, social contacts, physical functioning, smoking, weight, cholesterol level, functional far vision, and diastolic blood pressure, were among the measures of health outcome used. The only difference in outcome among the groups was in diastolic blood pressure and vision as measured by Snellen chart. For the group which did not have to pay any money for their health care the average diastolic blood pressure fell 3 mm and there was a 0.2 line improvement in far vision. Due to the large size of the study, these differences were statistically significant. Though the authors of the report seemed to regard these differences as also practically significant, their reasoning on that point is strained.

GOVERNMENT BY INSURANCE

Another common medical insurance plan today is pre-paid insurance. Health Maintenance Organizations (HMO's) are the best example. In HMO's an adjuster is installed other than the patient alone. Usually there is a coalition of adjusters: the patient (through limited reimbursement, and profit-sharing incentives), and the insurer (through profit-sharing and enforcement on "provider" hospital or physician).

In addition to the possibility that medical costs will not be controlled by such a bureaucratic scheme, HMO's pose ethical problems:

1. Is it morally proper for a competent free agent (the patient) to turn responsibility, hence authority, over medical care to someone else? As the temple of the Holy Spirit, may decisions regarding the care of our bodies be turned over to others who are subject to financial temptations to limit what is done for temple maintenance? (1

Cor. 6:19, 2 Cor. 6:16).

2. Is it morally proper for a physician to usurp the patient's responsibility? Is the patient's responsibility for his own health an inalienable trust from God? Should the physician accept governance of what will, or more importantly, what will not be provided?

3. Though the isuror and participating HMO physician may control costs in a given group, can the physician ignore persistent self-inflected injury by an individual? Is it proper to continue participation in a plan for which pays for, hence, endorses financially, persistent and willful self-destruction by the patient? Oughtn't a physician encourage personal responsibility, especially in a nation whose health is so substantially damaged by self inflicted diseases?

I have no firm answers. My working conclusion is that the patient has responsibility for his own health, and I am responsible only as an adviser and assistant. One obviously needs assistance to remove a sebaceous cyst from the interscapular region or to have one's eardrum examined. Neither should patients be expected to know as much about the human body and its malfunctions. But physicians cannot simply sell a contract, like Orkin, to keep the bugs out. We need patient's participation, and the wallet handle is one of the only ways some people can be induced to take the necessary interest. (Compliance with reasonable advice is another. Appointment-keeping is another. Truth-telling during data gathering is another. These have been the cornerstones of my decision making process regarding who will and who will not continue to be a part of my practice).

In addition to HMO's and indemnity insurance there exists a variety of other arrangements which usually amount to a pre-negotiated fee scheme. Patients pay a fee for each service, but plan members have pre-negotiated a lower fee for themselves compared to others. The plans go by various abbreviations such as PPO's or IPA's. In plans of this sort the physician becomes the adjuster for each visit, having pre-adjusted the cost in negotiations with the patient's agent. If there is a co-payment required, the patient becomes the co-adjuster. If there is no limit to number of patient visits, the system will not save money, even though cost per visit may be lower. Physicians can arrange to have the number of visits increase to offset the lower cost per visit. Patients can increase the number of visits if they think they are not receiving all the time and service they require. Presumable, a conscientious Christian physician could resist the temptation to arrange unnecessary visits and a reasonable patient would not want do so. What, though, of the idea of a fee that is lower for some patients than for others, for the same service? Proverbs 20:23 states, "The Lord detests differing weights, and dishonest scales do not please him."

Is the physician participating in a negotiated fee system as an act of negotiated charity? Is charity negotiable? If

not charitable, is he determined just to make less money? If not losing money on them, is he providing less care of overcharging other patients who receive the same service? The face appearance of pre-negotiated fees for some patients but not for others is one of differing weights. Other factors may rehabilitate the concept of negotiating fees for some patients. For example, some might defend them on the same principle as "loss leaders" in a grocery store. The physician makes it up in volume, and thus keeps the overall price down for everyone. Or, perhaps the physician considers other priorities higher than purity in billing, such as keeping a unique service available. Participation in prepaid systems may be the only way, a necessary compromise if some physicians are to continue in practice.

II. CONFLICT OF INTEREST IN PURCHASING

Though indemnity insurance is a good plan for medical insurance, it combines poorly with the feature by which someone else, usually an employer, pays the premium. Proverbs 20:14 states, " 'It's no good, it's no good!" says the buyer; then off he goes and boasts about his purchase". A purchaser who is not personally going to use a service will have more concern with the price than with the quality or availability of that service. Sixty per cent of the U.S. population has employer-paid insurance, 10% has privately paid, 6% has no insurance, the remaining 22% has some form of government insurance plan.[6]

When shopping for automobile insurance, I decided to save money on insurance by choosing a high-deductible policy for one car and by simply dropping the collision coverage and assuming the collision risk on another older car. On fire and windstorm coverage for my house, I obtained a combined policy with other risks to reduce costs, but convinced the company to allow higher coverage than they initially wanted to allow. This decision cost me money. I was weighing my pocketbook against risk protection. IF someone else were paying the premiums, I would be tempted to agitate for lower deductibles, and for coverage on the older vehicle.

Furthermore, though I find all insurance policies difficult to understand, I have made an effort to understand the ones I purchased. If someone else were buying, I might tell them what I wanted, and then assume that it was so, until I had a claim. At that time I might find that the coverage was not what I expected, and be angry either at the one who presented the bill for the services, or at the one who bought the policy. Most physicians have been in the former situation and, as employers, some of us may also have been in the former situation and, as employers, some of us may also have been in the latter situation. Not a tenth of my patients have any rudimentary understanding of what their medical policies cover or do not cover, nor what they cost. This is not a good situation.

Medical insurance can also disrupt the free market interaction between buyer and seller if the physician deals directly with the insurance agent for payment instead of with the patient. Years of profiting from an

easygoing relationship with insurers hooked many physicians into dependence upon the insurers for payment. Gradually at first, now with vigor, the insurers have tightened the screws on physicians and attempt to dictate the price and many other features of medical care. Their dependence has caused physicians to hesitate to admit to their insured patients that they are rationing their care due to lower payment and other constraints.

GOVERNMENT INSURANCE

By whatever insurance plan, the biblical role of government in health care is much more limited than now exists in U.S. There is insufficient space to defend this controversial assertion here. The reader is referred to such biblical texts as Rom. 13:1-7, and 1 Pet. 2:13,14 for statements regarding the purpose of government. I fail to find any biblical warrant for a government role in the provision of individual medical care. A warrant for public health measures could be made from Old Testament texts. Whereas public health concerns may include such issues as environmental carcinogens, they do not include whether to irradiate Aunt Mae's bone cancer, whether she should be admitted to a hospital, or whether she should be put on expensive intravenous hyperalimentation if the time comes when she cannot eat.

Christians who insist upon government involvement in such issues must not only show the biblical basis for the government involvement, they must show how to constrain the government to obey God;s law in managing individual cases. A government which will sanction millions of abortions, which usurps family authority to teach and discipline children, which allows experimentation with human embryos, etc., is not trustworthy to look after Aunt Mae's best interests.

Whoever pays for medical care will determine what is done, including what is not done. Government-paid medical insurance will determine medical practice. Exceptions to government involvement in individual medical care would be for those in its employ, such as soldiers, or under its sanction, such as prisoners of war and jailed criminals. A government which has slaves can control their personal medical care, a caution to me when I consider our own elderly and poor, who themselves and through their political leaders are rapidly selling their freedom to control their own health care for the security of having generic health care at little out of pocket cost. Trading freedom for security is one of the ways to become a slave (Cf. Ex. 21:6).

Some might wish to include government in medical care on the basis of government-managed charity programs. Government welfare, even if it worked, cannot be charity. That which is taxed, taken under threat of force, is not charity (II Cor. 9:7). Whether government-paid medical programs "work", or whether the health of those so covered is any better because of the programs, is beside the point if government involvement is not God's plan. The finest experimental design cannot reveal "true truth" to us, but mere utilitarian facts with a cultural relativity and a certain

half-life.

Suppose research showed that a completely government-controlled comprehensive health plan improved a population's physical health significantly over a 10 year period. A government-mandated vigorous exercise plan for youth, government policies on agriculture to limit the supply of excessive amounts of red meats, government-subsidized vacation, etc., could probably do this. Who would doubt that the population's health would improve? Such government action has already occurred -- in Nazi Germany. A population willing to be enslaved can, at least for a time, be healthier under some regimes. Though we do not have formal research into the effects on German health, an eyewitness has testified to the contrast he noted between vigorous German youth and scrawny British youth at the outbreak of World War II? What would have been his assessment at the end of the war? The youth of Germany were decimated by Nazism. Similarly, abortion is sometimes justified because it leads to a healthier population. Neither health nor longevity should be set up as the ultimate values, but rather God's revised will. Freedom comes at a cost; part of that cost is recognizing that some people will abuse their health or ignore their illness to their own detriment.

IF NOT GOVERNMENT, THEN WHO?

This brings us to another question: what of those who are truly afflicted with disease, who are not insured, or not properly insured. If government doesn't take care of them, who will? Should we just let them suffer, remain disabled or die? Hopefully not. Yet we should not erect a system designed to provide medical care for all while trampling on other biblical values. As stewards of limited resources we may seek to see those resources wisely distributed, but we have no guarantee that each individual's needs will be met, let alone his wants.

Genesis tells us that the earth has been cursed. Though it has many marvels, and though God's hand is evident in it to those whose eyes are open to the fact, there is something wrong with it. Trying to work in the southeast in a garden in the summer gives one an appreciation of the curse -- drought, weeds, hail, worms, bugs, animals, even small children all unite to destroy a garden. Dealing with disease in patients can be must the same, only more critical than tomatoes. If this premise of a curse, or a bent, damaged-but-not-destroyed nature is accepted as true, then we must realize that we do not have the option of undoing the curse, only ameliorating it for a time. All of my patients die...sooner or later...of something. By no material means, by no system of human organization, private or government, will we be able to eliminate disease and suffering. Our job is to make the best of what we have--stewardship. We are stewards of an omnipotent.God, not omnipotent ourselves. If He has not put the material means within our control, we surely have no warrant from Him to seize the means from others in the name of health.

In any nation people can be pointed out who do not have everything medically possible being done for them. This observation does not necessarily constitute and indictment of the prevailing system. The gaps need to be viewed in context of other accomplishments or drawbacks of that system. As mentioned, a slave state could probably achieve greater health for the population than a laissez-faire government. If we have a commitment to the "greatest health for the greatest number" without a commitment to other values such as freedom, we can have a healthier, more nearly enslaved population.

CONCLUSIONS

Though neither is an absolutely top priority, we are biblically committed to maintain our health (I Cor. 6:20) and to preserve or restore our freedom (I Cor. 7:21-23). What then, do we do about the gaps, if we are not to turn control over to government and insurance companies? From the foregoing the following strategies emerge for Christian physicians and church leaders:

1. Encourage medical insurance; it is encouraging a form of responsibility.

2. Encourage, where possible, insurance that has deductibles and co-payments which are substantial, i.e., as high as affordable for the family. This goes for individually purchased policies as well as for employers who offer plans to employees. First-dollar coverage encourages overuse of medical care. Virtually everyone is helped by having some hesitation to reach into his pocket. Money saved by avoiding first-dollar coverage should be invested to increase family assets and thus enable even higher deductibles, with more savings, in the future. The goal is to move toward insurance for medical disasters and away from insurance for more routine medical problems.

3. Encourage insurance policies which reward proper life-styles. Let those who willfully endanger their health take the extra expense. Let us not pretend that disease in the U.S. is always a random event that falls out of the sky onto innocent, non-participating victims. Except near the limit of our life span, the evidence is that we bring disease on ourselves much of the time.

4. As "providers", health care personnel should refrain as much as possible from dealing directly with third parties. IT disturbs the restraints of the marketplace and reinforces the already prevalent notion among people the their health care is someone else's responsibility financially and otherwise.

5. Laws that tend to reconnect the purchaser of the policy with the beneficiary of the policy should be supported. At the present time this is seemingly an unattainable dream as Congress contemplates requiring all employers, even small businesses, to offer medical insurance to all employees. An interim step might be to allow employers to: (a) share savings in cheaper plans with their employees; (b) set up illness contingency funds within the company, which employees would have

access to for expenses not met in otherwise high deductible policies, and in which the could share in revenues for sums not expended.

6. Encourage charity. The practice of it is one of the better ways to encourage it. Could your church begin in a small way its own medical charity? Be sure not to operate it the way insurance companies do. Personal charity has the amazing advantages of including those frozen out of insurance, of the admission of limits to medical care, of taking into consideration all of the needs of the Kingdom, and of supervising individually the recipient's participation in his/her own health. (Again, recently, a patient revealed some substantial financial hardship regarding the cost of her needed chronic medications. My heart was soft but my head was hard. She was literally burning up $2.50 a day in cigarettes, more than the cost of the medicine. My head prevailed. I am sorry for her plight, but I will not underwrite her self-destruction by cigarettes and call it love. An insurance company cannot individualize its dealings in such a manner).

7. Where possible, whatever the payment source, reason with the patient and family regarding the wisdom of unrestrained use of medical care at death's doorstep. Those deathbed dances are not only expensive for somebody, they often merely prolong the act of dying. We are not physically immortal, and all the resources of our selves, our insurer, our physician and our government cannot purchase immortality for us. If we try to pretend that government or insurance resources are sufficient, we are promoting the trend for both to restrict medical care, very likely on ungodly grounds, and otherwise enslave us.

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