Guest Editorial

Putting Universal Healthcare on the Religious Agenda

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In modern industrial society the issue of access to healthcare is inseparable from the question of whether there is a right to healthcare and whether government has the correlative duty to assure a minimum level of care to all citizens. While discussion in terms of rights and duties tends to direct our attention to broader, more theoretical ethical issues, discussion in terms of 'access' invites consideration of more practical concerns. The news media rarely report in terms of whether a citizen's right to healthcare has been abridged or disregarded, but rather offers tales of people being denied access. Advocacy groups for specific illnesses do not necessarily argue for universal health insurance, but rather press that certain conditions, such as renal failure requiring dialysis, receive unlimited insurance coverage and that people with the condition be given automatic access to care.

Access to healthcare involves two critical considerations: access for whom and access to what? Clearly, our attention is most easily captivated when one person is treated and another denied care for the same illness. Thus, a decade ago we witnessed the spectacle of the United States President appealing for private funds to assist a child needing liver transplantation while at the same time opposing government expansion of basic health insurance. Dramatic and publicized denial of access tugs at our hearts and compels social or political action. Covert denial easily passes unnoticed.

The United States is criticized, both at home and abroad, as the only developed nation in the world that does not automatically provide all citizens with healthcare. But, some argue, this denial of access is more apparent than real. Between health insurance connected with work, Medicare, and the availability of Medicaid and emergency treatment, almost everyone can get care. Yet, there is great variability in the ease of access. Working-class individuals without health insurance may need to exhaust all savings before public assistance becomes available. Such individuals may routinely avoid or delay care to protect small savings that would not be threatened if the United States offered a more comprehensive system of access to healthcare.

Many European countries, however, have a two-tiered healthcare system with a public sector providing care rationed primarily by time spent in queue and a private system providing unlimited care and immediate access for those who can pay. The waiting time for hip and knee replacement in England and Norway may be years while in the United States these procedures are available immediately for almost all citizens. Also, the level of medical care is highly dependent on the quality of physicians—their diligence and their intelligence. Universal access is most easily conceived in terms of the availability of drugs,

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routine diagnostic tests, well baby care, and preventive care, especially routine maternity care and vaccinations of early childhood. But as care advances beyond simple, routine procedures the difference between universal access and equal access can be profound. In Great Britain, the dockworkers of Liverpool and the inner city residents of Manchester do not get the same access to thoughtful attention as the families of Oxford University faculty.

The papers collected in this journal section present perspectives on access to healthcare from major religious perspectives. This selection is not intended as a comprehensive survey of religious views: access to healthcare is a complex issue and varieties of answers can be offered from each tradition. Rather, this section is intended to spark debate and fan discussion within the congregations of organized religion and in the meeting houses of community groups. Lawrence Brown, in his paper "Health Reform in America: The Mystery of the Missing Moral Momentum," clearly sees affordable universal coverage as the only reasonable long-term goal. He explores how it is that the United States can spend more than other countries on healthcare and yet not be committed to a clearly specified minimum level of care for all citizens. Richard McCormick, in presenting a Catholic perspective on access to healthcare, focuses on the right to healthcare and the duty to provide care. A societal responsibility to provide access, especially for the poor, becomes the realization of this positive right. Allen Verhey and Noam Zohar, in their papers on Protestant and Jewish perspectives, also emphasize the duty of the community to provide care for all. But, given the limits of community resources, they struggle to identify religious grounds for rationing care and limiting access.

In reading these papers one is struck by the realization of a previous relative silence from religious leaders in an often raucous public debate on universal healthcare. To the extent that religious leaders have avoided speaking out on the issue, the papers in this section can take the lead in putting universal healthcare on the religious agenda. To the extent that religious leaders have not been silent, but rather too few have been listening, we should be particularly attentive to the questions raised and the answers suggested by Lawrence Brown on the "missing moral momentum" in our national debate on healthcare policy.