INTRODUCTION

Currently, in synagogues across the world, Jews are reading from the Book of Leviticus about matters of piety, practice, and the issues of health. As a people, we have always been conscious and concerned with the issues of health and well-being as an integral part of our communal system.

Maimonides would identify health care first on his list of the ten most important services that a city had to offer its residents (Mishneh Torah, Hilchot De'ot lV: 23). In his Guide to the Perplexed, he suggested that "The wellbeing of the soul can be obtained only after that of the body has been secured."

Almost all self-governing Jewish communities throughout history set up systems to ensure that all their citizens had access to health care. Doctors were in fact required to reduce their rates for poor patients, and when that was not sufficient, communal subsidies were established. Bikkur Holim societies represented a communal response to the principle for caring for the sick. The focus on health as seen from the tradition and our institutional practices are aligned with the idea of holiness, kidushim and acts of care, gemilut hasodim, values and themes that do not resonate within our general society today.

America today is suffering from a health care crisis. Some have described this situation as the "medical-industrial complex" (Arnold Relmn, New England Journal of Medicine in 1980). The cost of maintaining the current American health care program accounts for 1.6 trillion dollars annually or 15% of our

economy. National health care costs doubled in this nation between 1990-2000, and these costs, it is estimated, are rising at 7 to 9 percent annual rate. Our nation spends one-third more on medical care per capita than the next closest society, Switzerland.

Yet, despite this outpouring of resources, it is estimated that nearly 45 million Americans have no health insurance, and according to the United States Census Bureau (1999) of this number, 10 million are children. Each year, according to researchers (Himmelstein and Woolhandler, 1994) 18,000 uninsured and underinsured Americans die prematurely for lack of affordable medical care. Similarly, United States has one of the highest infant mortality rates in the civilized world, which can be directly attributed to a lack of affordable health care coverage. Many of those who lack coverage receive significantly lower levels of care than those of us who are insured, and suffer from lower life expectancy, and from the painful effects of untreated chronic diseases.

How can we ensure that all Americans receive the quality of health care that they require and deserve? No small order for a Sunday afternoon discussion.

To help us explore the challenges related to the politics of health, I am joined by three extraordinary individuals, each knowledgeable in different aspects of our complex and most troubling subject.

Dr. Alexandra Levine serves as the Medical Director of the USC/Norris Cancer Hospital and has been Chief of the Division of Hematology at the USC School of Medicine since 1991. In 1995, she was appointed by President Clinton to Chair the Research Committee of the Presidential Advisory Council on HIV/AIDS. She has served as a member of the Board of Councilors of the National Cancer Institute and is currently a member of the Board of Counselors of the American Society of Hematology. Dr. Levine has acted as principal investigator or co-investigator on over 20 research projects, many of them funded by the National Institute of Health or the National Cancer Institute. She has published over 300 articles and book chapters. In 1997, she received Evelyn Hoffman Memorial Award in recognition for her achievements in lymphoma research and patient care.

Our second presenter will be Supervisor Zev Yaroslavsky who represents the Third Supervisorial District within Los Angeles County.

First elected in 1975 to the Los Angeles City Council, Zev served in that chamber until 1994 when he was initially elected to the Board of Supervisors.

Currently, Zev serves on the Board of Directors of the Metropolitan Transportation Authority, the Los Angeles Coliseum Commission, and as a governor's appointee to the state Board of Corrections.

Within the County government, he has firmly established his leadership in budget matters, repeatedly challenging an entrenched "business-as-usual" mentality that has severely compromised the County's ability to provide critically needed health, welfare and justice services in a fiscally prudent manner.

Among his major accomplishments, in areas related to our discussion this afternoon, as Supervisor, he has worked closely with County Department of Health Services and Service Employees International Union Local 660 (representing some 40,000 County employees, nearly half of them in the Health Department). He spearheaded in November of 2002 the successful passage of Measure B, a parcel-tax increase, approved by an overwhelming 73% of voters, designed to yield $168 million annually to fund trauma care, emergency services and bioterrorism preparedness efforts. Further, he helped to engineer the rescue and restructuring of the County's Department of Health Services when it was facing collapse in 1995.

In 1998 he initiated a lawsuit against the tobacco industry, yielding a settlement which returns to the County more than $100 million annually for health programs.

As President of the Los Angeles County Prop. 10 "Children and Families First" Commission, he was instrumental in 2002 in spearheading state funding that allocated $100 million in tobacco-tax funding over five years to ensure health care coverage for virtually all children from birth to age 5 in Los Angeles County.

Supervisor Yaroslavsky is a lifelong resident of the district that he represents. A graduate of UCLA, from which institution he holds a Masters degree in history, and a Bachelors degree in history and economics. He is married with two children.

Our final presenter this afternoon will be Andi Milens who is the National Director of Community Relations and Communications for the Jewish Council for Public Affairs (JCPA). Her primary responsibility is to assist the agency's 123 member CRCs in their daily work addressing important issues of community relations and public policy. She also oversees implementation of the UJC/JCPA Israel Advocacy Initiative, a two-year, $1.7 million nationally-coordinated strategy for Israel advocacy. Andi is also the director of JCPA's Task Force on Equal Opportunity and Social Justice, which addresses a broad range of issues such as poverty, health care, public education and immigration.

Prior to joining the JCPA in April 2002, Andi spent nearly seven years with the Jewish Community Federation of Cleveland. As an associate responsible for refugee resettlement, Andi was the local expert on welfare reform and refugees and was relied upon by the state of Ohio to assist with policy formulation and implementation.

As Director of Government Relations she worked with the Federation's agencies to secure and maintain over $58 million in government funding.

From December 1999 through March 2002, she was the Cleveland Federation's Director of Community Relations.

Andi holds a masters degree in Jewish Communal Service from the Hebrew Union College, and a masters degree in Public Administration from the University of Southern California. She earned her bachelor's degree at Washington University in St. Louis.

Upon the completion of our four presentations, you are invited to submit written questions or comments. Individuals will be moving through the sanctuary at that time collecting your 3 by 5 cards. Thank you in advance for your participation and cooperation.

I am pleased at this time to invite Dr. Alexandra Levine to address us.

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The politics of health is specifically significant to our community:

Yet, there is little evidence that the significance and impact of this issue has yet to penetrate the policy or program initiatives of our national or communal agencies. Outside of but a hand full of our major religious, membership and policy organizations, one can not find this subject matter on the American Jewish communal agenda.

For some organizations, it is presented only as a segregated educational component, directed toward one's personal physical wellbeing, and for others, this is merely introduced in a generic context. In a few settings the bio-medical debate has evoked a level of interest, more specifically around the intersection of Jewish law and ethics and medical practice.

Primarily, the Reform movement through its Religious Action Center and its rabbinical conference, the CCAR, and the Jewish Council for Public Affairs have specifically addressed the legislative and policy implications associated with the array of issues around health cost, quality, and access along with the broader implications of how this issue intersects with the questions of poverty, economic justice, and social responsibility.

Clearly, there are long term policy considerations over reconstructing the health care system. But there are immediate considerations as well. Let us for a few moments examine two of these current issues.

As we know, many employers are scaling back coverage or dropping benefits entirely—and as competing employers follow, we may reach a tipping point when the system collapses. Nationally, the percentage of workers receiving coverage from their employer in 2004 was 61%, down from 65% in 2001, with at least 5 million fewer jobs providing health insurance in the past three years.[i] In California these figures are even more daunting. One analysis found 62.9%

of U.S. residents under 65 are in employer-based coverage, but only 57% in California (and 49.6% in LA).[ii]

Moreover, 57% of employers nationally and 44% of California employers increased employee cost-sharing last year, and 17% of U.S. and California firms reduced the benefits covered. In the future, two-thirds of employers are likely to increase employees' share of cost, while 9% report plans to drop some or all coverage for employees and dependents.[iii] Finally, while health costs have increased for employers, workers have seen even greater increases. Over the past three years, total premiums increased by almost 42%. Yet worker contributions increased by nearly 70% (from $1,450 in 2000, to $2,452 in 2003) over this same period.[iv]

The second area of immediate concern involves the role of government in meeting its obligations to uninsured and underinsured through Medicare and Medicaid-type assistance programs. As we know, various public insurance programs have been targeted for cuts and reductions. In an effort to balance the federal deficit, the President is proposing budgetary caps over the next ten years on such programs. In this state, our Governor has proposed significant cuts in health benefits that would deny coverage to hundreds of thousands of children, seniors, and people with disabilities, and additional policy changes that will restrict access to care for thousands of others. Last year, the proposed cuts included major rate reimbursement reductions to Medi-Cal providers, as well as caps on programs that served the most vulnerable.

The politics of health care has undergone a fundamental revolution in America.

At the outset, what we need to recall briefly is the history of the American health industry. Prior to the 1970's, our system of medicine could best be described as a series of personal transactions, based on the interaction between the patient and his/her doctor. In his excellent summary of the history of American medical practice Arnold Relman writing in the New Republic in March of this year noted that in the 1970's and beyond, as a result of market forces, new medical technologies and drugs, the influx of large numbers of newly trained physicians, and a corresponding new focus by the courts on sanctioning competitive and commercial activities within the medical arena, this nation experienced a fundamental reorganization of its health care structure.

This transition in American health practices has profound implications for the Jewish community. As both consumers and concerned citizens, we engage this discussion. In order to do so, we will need to examine the Jewish engagement through several lens.

Demographically, Jews are significantly older than other key ethnic, racial and religious constituencies in the United States. In 1960 people 65 years of age and older constituted 9% of the population, in the year 2000 that percentage was

nearly 15%. Yet among American Jews the numbers are significantly higher. The median age of the Jewish population is currently 48, five years older than the median Jewish age in 1990 and seven years older than the overall median age for the U.S. population, according to the National Jewish Population Study. Nearly 20% of American Jews are classified as elderly, defined as 65 years of age or older, compared to 12% of this nation's total population.

As a result, one would expect that as a cohort, Jews will become more dependent on medical services and quality care delivery more immediately than other constituencies. Both in response to the growing attention that this issue will inevitably create for Jewish families in search of quality care, and with reference to the general concerns being expressed by Jews over the ethical and social implications to construct an equitable and accessible health care system, there ought to be a coordinated and defined Jewish communal engagement with the issues and politics of health.

Four principle factors ought to drive the health care discussion within our community:

1. In light of the demographic data just referenced, Jews will be increasingly consumers of health services, prompting our attention and broader engagement with this issue.

2. This subject affords our community an opportunity to develop new community-based coalitions, as other groups share similar concerns in matters of both health delivery and public policy.

3. This represents a critical intersection point linking other social safety net concerns that have long been public policy priorities for our community when dealing with poverty, education, and job-creation, and finally,

4. Because it is a moral imperative. Jews have an historic commitment to the principles of insuring access to medical care for all.

Researchers writing in the Annuls of Internal Medicine (February, 2003) identified seven principles that can be used for the reconstruction of primary care and the health care system. When examining the Jewish communal responses to the policies and politics of health, these themes seemed to reflect our interests and hold to our standards.

1. Health care must be organized to serve the needs of patients. Much of the current organization of medical care is structured to accommodate incentives in the reimbursement system and the preferences of providers, often with patients' needs included only as an afterthought.

2. The goal of primary care systems should be the delivery of the highest quality care as documented by measurable outcomes.

3. Information and information systems are the backbone of the primary care process. Today's health care information systems were designed primarily in response to administrative needs, with reimbursement at the top of the list. These systems rarely collect information that allows management of a patient's needs over time or an assessment of the effects of care on patient health. Specifically, medical records should remain with the patient and be interactive for patients and providers alike.

4. Current health care systems must be reconstructed. The American health care system is a complex and fragmented set of providers, facilities and services that have been created based on requirements for reimbursement and the needs of providers. The system should represent a balance of control between the provider and the patient, outcomes oriented, structured to address the needs of the population and focused on the ongoing relationship between a patient and primary care provider.

5. The health care financing system must support excellent primary care practice. Such changes must, at a minimum, include counseling patients about their health and their medical options and being an advocate to guide patients through the health system.

6. Primary care education must be revitalized, with an emphasis on new delivery models, including team-based medical services, and training in sites that deliver excellent primary care.

7. The value of primary care practice must be continually improved, documented and communicated.

These seven concepts resonate to a similar set of generic standards initially addressed in 1993 by the NJCRAC when it constructed its Principles of National Health Care Coverage. It should not be lost on us that these principles coincided with the Clinton Administration's abortive efforts to construct a national health care program.

Included among these core objectives were

a. Universal Access
b. Comprehensive Care involving Prevention, Early Diagnosis and Screening. Availability of Care, and Access to Long Term Care
c. Choice of Health Care Providers
d. Equity, Efficiency, and Quality
e. Cost, Coverage and Financing
f. Health Care Provider Education
g. Innovation and Research

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With reference to the more specific or targeted interests of our community, in my review of the organizational responses, the following categories of policy and practices were evident.

Among the key agenda items, is the call for a Patients' Bill of Rights and other consumer protection initiatives that include an effective independent external appeals process; provide emergency room access; guarantee access to specialists, out-of-network providers, and obstetrician/gynecological services, and allow patients to keep their doctors or health care professionals; improve patients' access to HMOs' rules and regulations; and ensure the privacy of medical records.

A second area involves the insurance-related issues which would include coverage for prescription drugs and long term care and access to discounted generic drugs while also advocating that the Children's Health Insurance Program (CHIP) be adequately funded and implemented.

Finally, a third set of concerns has been centered on funding issues that call for adequate support for HIV/AIDS patients and research, along with a renewed attention to those persons who were uninsured who are often left to depend on community clinics, public hospitals, and other "safety-net" institutions for their care. Connected to this initiative are the proposals for the restructuring of Medicare**.**

The discussion over health care and coverage remains an on-going part of the political discourse in this country. Indeed proposals abound regarding tax credits to help people with low to moderate incomes to purchase insurance*;* tax incentives for family members providing

long term care; Medicare prescription drug benefit packages and the reform of the medicare program, and health care savings accounts.

Beyond the tasks of repairing the American health system, there remains the whole array of social values and public policy questions that this nation must also consider. The bio-medical controversies over organ donation and transplants, stem-cell research, and the right to die have left the country divided but require further engagement and action.

The state of the American health care system is a subject that will require on-going inquiry and significant public participation. And the Jewish community must be a voice in that discourse. We have a vital stake in these diverse and complex issues. To help us understand and explore those avenues of advocacy and action, I am pleased to invite Andi Milens to share her thoughts.

[i] Annual Employer Health Benefits Survey by the Kaiser Family Foundation/HRET, September 2004.
[ii] 2004 March Current Population Survey, analyses by UCLA Center for Health Policy Research.
[iii] "Insurance Markets: Health Benefit Costs: Employers Share the Pain." The California HealthCare Foundation, July 2003.
[iv] California Employer Health Benefits Survey, by Kaiser Family Foundation/HRET. March 2004.