Mennonite Healthcare Fellowship

Mennonite Health Journal

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This issue of *Mennonite Health Journal* follows up on Mennonite Healthcare Fellowship's Annual Gathering 2013, held June 21-23, 2013 in Goshen, Indiana. Some articles come directly out of presentations given at that event. Others are further reflections based on the theme, "Moral Dilemmas in Healthcare." All of them have some connection with how Christians respond with the ministry of healthcare in a changing world.

Goshen College student reporter, Twila Albrecht, paints an **overview of the Annual Gathering** for the benefit of both those who were not present as well as those who were.

The **opening keynote address by Timothy Stoltzfus Jost**, a recognized national expert on healthcare law outlined both the moral dilemmas that led to healthcare reform as well as the issues that are coming out of that reform, especially as many provisions of the Affordable Care Act take effect in 2014. Jost has graciously condensed and shaped his meaty presentation into a readable article. MHF members are welcome to request the original version from the MHF Office.

Paul Leichty, MHF Executive Director and MHJ Editor, follows with an editorial reflecting on moral dilemmas and the choices we make.

As this issue of MHJ was being assembled, the MHF Office learned of the death of a remarkable Paraguayan Mennonite physician, **Hans Edgard Epp**. Through the gracious contributions of Epp's widow, Ingrid Kaethler Epp and the help of translators, we are able to present in English a glimpse of this pioneer who throughout his life faced the dilemmas of education, public health, and a multi-cultural environment.

Finally, Canadian physician, **Murray Nickel**, presents us with one happy resolution of an all-too-common dilemma of how to marshal resources for education, public health, community development, and change in developing countries.

Watch for more articles in forthcoming editions of *Mennonite Health Journal*.

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Moral Dilemmas in Healthcare

A Report on Annual Gathering 2013

By Twila M. Albrecht

When despair for the world grows in me… I rest in the grace of the world, and am free.

Mennonite Healthcare Fellowship's Annual Gathering took place June 21-23, 2013 on the campus of Goshen College. The theme for the weekend was "Moral Dilemmas in Healthcare."

Folk musicians, Gwen and Les Gustafson-Zook, set the tone at the first plenary session on Friday, June 21, by leading in worship and singing. Gwen opened with a reading of Wendell Berry's poem, "The Peace of Wild Things." "In the midst of troubling realities, let us rest in the grace of the world," said Gwen.

Joseph Longacher, President of the Mennonite Healthcare Fellowship (MHF) board, welcomed the group to a weekend of discussion and prayer. Longacher suggested replacing the word 'dilemma' with a new word, polylemma, since in many cases there are many aspects to an issue, not just two poles. As faithful caregivers in the midst of a rapidly changing healthcare system, there are many predicaments that demand our attention.

Following a brief introduction, Longacher welcomed Timothy Stoltzfus Jost, guest speaker for the evening. Jost holds the Robert L. Willett Family Professorship of Law at the Washington and Lee University School of Law, and is co-author of the major casebook *Health Law*. In his presentation, "Challenges of a Changing Healthcare System," Jost discussed the complexities of the new Affordable Care Act, focusing on how national policy influences access to care and affordability. Jost challenged the audience to consider how we might improve access and the quality of healthcare while maintaining a sustainable economic system by tapping into Mennonite values of service to "the least of these" and doing more with less.

Jost also acknowledged that with these rapid changes in our nation's healthcare system, instability is expected. Questions arise: Can we find common cause with global systems? How

do we eliminate waste expenditures? How do we transform the educational process and influence future students to consider incorporating a team approach to healthcare? These questions inspired what became a weekend of constructive conversation and reflection.

On Saturday morning, Patricia Ebersole Zwier, a social worker and counselor at Oaklawn Psychiatric Center in Goshen, provided lessons on overcoming fear and anxiety in her presentation, "Don't be Afraid." "Within the healthcare profession, the weight of well-being of others is on our shoulders," said Zwier.

"Anxiety is within all of us, to some degree," said Zwier. "As we name and respond to anxieties in our own lives, we can better serve others." She went on to note moral dilemma of how we transform fear into greater health in a culture of anxiety. She lifted up the faith component and the importance of community. "We are not alone – God's plan is for community," said Zwier. We need to recognize anxieties and the need for each other and for community.

Following Zwier's presentation, participants were invited to attend workshops, some following up on the plenary presentations from Jost and Zwier, and others ranging from the practice of gazing prayer to the formation of international partnerships.

Dan Schrock, co-pastor at Berkey Avenue Mennonite Fellowship in Goshen, Indiana, led the workshop "Enhancing Our Compassion: The Spiritual Practice of Gazing." Looking at someone long enough engenders love in us, just as we can behold the glory of God through the person of Jesus, said Schrock. The challenge is keeping our eyes open to perceive the image of God in others.

Glen E. Miller, retired physician and author from Goshen, led in a workshop entitled, "Everyone Deserves to Die Well." He shared from his own personal and professional experiences, talking about the role of practical planning for a "good death" that includes the application of theology and values to healthcare decisions made in the process of dying.

Willard Swartley, Professor Emeritus of New Testament at Anabaptist Mennonite Biblical Seminary (AMBS), shared material from his most recent book in a workshop entitled "The Church's Mission in Healing and Health Care." Swartley shared an overview of Biblical perspectives in healing and healthcare, noted some aspects of church's mission in healing and healthcare through the years, and shared from his own personal health experiences as they related to present-day challenges in healthcare.

Lora Nafziger, a clinical social worker at Oaklawn, led the workshop "Trauma and Spirituality." Spiritually, someone experiencing trauma may feel emptiness, cynicism, and loss of apathy or growth, to name a few. An individual may feel that God is punishing them or some other sort of disconnect that causes a lack of spiritual intimacy with God, said Nafziger. The challenge is seeing, and helping others to see, the evidence of God's love, trust and protection in these experiences.

Murray Nickel and John Martens, from International Mennonite Health Association (IMHA), led a workshop titled, "Transnational Partnerships for the 21st Century: Joys and Challenges." Special guest, colleague and friend, Gaspard Mahuma, a physician and Mennonite leader from the Democratic Republic of Congo (DRC), was able to join Nickel and Martens for their presentation on successful partnerships and their experience in the DRC.

The IMHA leaders have been working with Mahuma for seven years to help assess the discrepancy between need and resources within the Congo. IMHA supports initiatives that seek to narrow this gap. Using the DRC as an example, Nickel asked, "How can we put together a tool to help people tell us what they're doing?" Nickel also explained the importance of the community in the process. The goal in this partnership is to fill another avenue for people to promote what they're doing through community of faith.

"Problems have to be solved by people on the ground," said Martens. "We [in North America] can help, but we can't fix the problem." In other words, the solution for healthcare issues needs to come from the context and setting of the culture, not from powerful organizations "dumping money out of an airplane." "Relationships are key," said Martens and Mahuma.

On Saturday evening, Nelson Krabill, President-Elect of Mennonite World Conference, led a panel of five local health care leaders in a discussion on, "Healthcare Access for All." The panel included James Nelson Gingerich, co-founder of Maple City Health Care Center; Randy Christophel, President and CEO of Indiana University Health Goshen; Clare Krabill, Executive Director of the Center for Healing and Hope; Darrin Miller, Director of Access & Risk Services at Oaklawn; and Mark King, President and CEO of Greencroft Communities.

Each of the panelists noted a particularly pressing dilemma regarding healthcare access in their own work. "Closing the gap is critical," said Christophel. He noted ways in which the hospital has built creative partnerships with other organizations to address community healthcare needs.

Affordability, availability and continuity are three major dilemmas that need to be addressed right here in this community, explained Clare Krabill.

"Income disparity is a justice issue," said James Nelson Gingrich. "We need to continue treatment without regard to status." He noted some creative ways in which Maple City Health Care Center worked with patients with financial issues during the economic recession.

Mark King spoke from not only his perspective as Greencroft CEO, but also as Board Chairman of IU Health Goshen Hospital. He pointed out that there is a market that the community competes with for the best talent. "We need to pay more money for certain specialists. How do we keep up with need for physicians while keeping salaries at the justice standpoint?"

Closing the discussion, Nelson Kraybill asked the question, "What do you wish for the church's role or responsibility to be?" "Needing help bears a social price," said Darrin Miller. "There's a stigma." If the mission of the church is to help your neighbor, then knocking down stigma issues is important." Clare Krabill echoed Miller's concern. "Fifty percent of our patients struggle with a mental health issue, and yet for a working adult to walk into a charitable clinic is hard," said Krabill. Gingrich pointed out that Maple City HCC is "a community of reconciliation and our entry point is through medical care," He cited the need to continue neighboring beyond racial and economic barriers. Finally, King brought up the importance of teaching youth that the church needs them in these positions.

"We need leaders with a vision of justice, compassion and healing," said Kraybill in conclusion. "God has called us to do reconciling, healing work in the world."

On Sunday morning, Ervin R. Stutzman, Executive Director of Mennonite Church USA, brought the message in a joint worship service with College Mennonite Church. In his sermon entitled "Healing as a Gift of God's Grace," he proclaimed out that God's grace allows us to work through the polylemmas we face in the health care system.

"Jesus doesn't need to be persuaded of who deserves healing," said Stutzman. "We are not deserving of God's healing, but we are worthy of God's grace."

As the weekend came to a close, one final question was presented in the wrap-up session: "What signs of God's grace have you recently seen in

your work?" Participants joined in sharing their morning offering with the local Center for Healing and Hope as well as Mennonite Central Committee's Menno Sante project in the Congo. A concluding communion service was led by Stutzman and MHF Executive Director, Paul Leichty.

The weekend theme fit well with the larger mission of Mennonite Healthcare Fellowship to be an organization in which Anabaptist healthcare workers can integrate their faith and their professional life. MHF was formed in 2011 when Mennonite Medical Association and Mennonite Nurses Association joined to form the new organization open to all types of healthcare workers. MHF announced that next year's Annual Gathering will be held June 13-15 at Laurelville Mennonite Church Center, Mt. Pleasant, Pennsylvania.

Twila M. Albrecht is a student at Goshen College from Goshen, Indiana.

Challenges of a Changing Health Care System

Timothy Stoltzfus Jost

The American health care system is undergoing revolutionary changes. These changes present major challenges to health care providers and consumers. These challenges take many forms-economic challenges, capacity challenges, challenges to authority, and challenges to doing things the way we have always done them. But we also face moral challenges—moral challenges presented by the changes our health care system is undergoing and moral challenges that are motivating these changes.

This article begins by discussing **our current health care system**. Second, it will examine the **changes currently taking place**. In particular, it will focus on the Affordable Care Act and the changes it is driving. Third, it will address the **challenges those changes are presenting to us**, and in particular the moral challenges.

Our Changing Health Care System

As we look at our current health care system, three characteristics stand out. **First, access to health care in the United States has been determined primarily by insurance**. Private insurance, our predominant form of coverage for working age Americans, has been employment-based and risk-based. Public insurance has only been available to those who have a good reason for not being in the job market and who are, by and large, not insurable—the old, the disabled, dependent children. Insurance often also excludes coverage for pre-existing conditions, which are often the primary reason that people seeking insurance need it. We are moving toward a system in which health insurance will be available to most Americans regardless of health status, employment status, and wealth. Some, such as undocumented aliens, will still be excluded, but far more will be included than before.

Second, our system has been doctor and hospital centered, and focused on the treatment of acute illnesses and accidents. Since the nineteenth century, the scope of practice of all other health care professionals has been defined more narrowly than that of the physician and in many instances has been defined in relationship to that of the doctor. Doctors and hospitals in the United States have also focused on the care of individuals rather than populations and on acute conditions rather than on community and clinical prevention or on maintenance care for chronic conditions. We are moving to a system that will at least be somewhat more patient-centered, possibly more population-centered, and that will focus more on prevention and on maintenance care for chronic conditions. It will be more integrated and coordinated, and less dependent on doctors and hospitals.

Third, our system has been characterized by fee-for-service payment. We are moving to a system of more global payment, and hopefully payment based more on value and outcome. We are also, however, moving toward a system where patients will continue to bear more of the immediate cost of their care.

The health care system built on these fundamentals has functioned tolerably well for most Americans. For the last fifty years, most Americans have been able to access medical care when

they have had serious accidents or diseases. Diseases that killed alarmingly high numbers of children in previous generations have been prevented by vaccinations or cured by antibiotics. Life expectancy grew by over 60 percent over the twentieth century. Insurance has shielded most Americans from devastating financial ruin in the face of medical problems, even when they have been faced with serous illnesses or accidents.

But as we all know, our system has had glaring deficiencies, and has not worked for everyone. During 2012, 55 million working age adults, 30 percent, were uninsured at some point. Since insurance is normally based on employment, a loss of employment, however temporary, has usually meant loss of insurance. Thirty million working age adults are also underinsured. Even though they have insurance, it has serious gaps exposing them to financial disaster if they are seriously ill or injured. Although one function of health insurance is to secure access to care, another very important function is to protect us from financial ruin, and to secure the payment of providers who have provided us services.

This does not mean that these Americans necessarily die in the streets for lack of medical care, although some have. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that participate in Medicare and that have emergency departments to screen and stabilize people who present in an emergency regardless of ability to pay. But, as we all know, emergency rooms are a very inefficient way to provide basic health care. And EMTALA does not require hospitals, much less the doctors who practice within them, to provide care for free. Many uninsured people avoid emergency rooms because they do not want to assume the debt that they will incur if they use their services. And hospitals face huge uncompensated care burdens that they try, not always successfully, to transfer to other payers.

America also has by far the most expensive health care system in the world. Our health care delivery system costs $8680 for every man, woman, and child in the U.S. It consumes almost 18 percent of our GDP. We spend more on healthcare than we spend on housing, on food, on transportation, on anything else. What is even more striking is the opportunity cost of our healthcare system, the opportunities we lose because of our excess health care spending. Over the past 30 years, from 1980 to 2010, the gap between the per capita spending of the U.S. on health care and that of Switzerland, the second most expensive country, has been 15.5 trillion dollars. With $15.5 trillion, we could have:

- Turned the U.S. $11.6 trillion federal debt into a $3.9 trillion surplus,
- Sent 175.4 million students through a 4 year college,
- Cover an area the size of South Carolina with solar panels, or
- Bought everyone in the world four iPads.[1]

Finally, the quality of the American health care system is not exceptional. We do a reasonably good job of treating acute conditions and actually do quite well with prevention and in treating certain cancers. But we don't do as good a job with many chronic illnesses. One of the few comparative surveys found the U.S. to be the worst among nineteen nations in terms of deaths preventable by medical care.

[1] http://www.commonwealthfund.org/Blog/2013/Mar/The-Road-Not-Taken.aspx

Our current health care system is neither economically sustainable nor morally defensible. It must change, and it is changing. How is it changing? What are the challenges that change presents?

How the Affordable Care Act is Changing Health Care

In 2010, Congress adopted the Affordable Care Act. This law set us on a path toward wide-ranging, if not quite comprehensive, reform. The primary focus of the ACA is obviously expanding access to health care financing—public and private.

The law attempts to do this by building on our current system. It is fundamentally a conservative piece of legislation. First, **the law requires large employers**—defined as those that employ 50 or more full-time or full-time equivalent employees, **to provide their full-time employees and their children with health insurance coverage or pay a tax**. Currently 98% of employers with 200 or more employees and 94% of employers with 50 to 200 employees offer health insurance, so this is not a radical change. But if large employers do not offer affordable and adequate coverage and one or more of their employees end up in the exchange, receiving premium tax credits, the employer will owe a penalty.

The nongroup or individual market will also change significantly under health care reform. Currently nongroup coverage in most states is health status underwritten. If you are young and healthy it is quite affordable; if you are older and unhealthy it is less affordable and may not be available. Health status underwriting and preexisting conditions clauses will be banned in all markets as of 2014. In the individual and small group market, the only rating factors that will be allowed are age, with a 1-3 variance, tobacco use, geography, and family composition. The law also does not allow underwriting based on gender or occupation. In general, rates will go up for young men; down for older people and women all other things being equal.

Coverage will be standardized as to benefits and also as to cost sharing. All plans in the individual and small group market must cover the essential health benefits, defined in most states by one of the most popular small group plans. All must be arrayed into four levels of cost sharing. Catastrophic coverage will also be available for some. Also cost-sharing reduction payments will limit the financial exposure of lower income enrollees, particularly those under 200% of the poverty level.

It is unclear still what the risk mix will look like in the nongroup and small group market. The individual mandate is intended to encourage healthy people to purchase insurance, but it is quite weak, and if insurers price their policies expecting only unhealthy people to buy it, they may drive healthy people out of the market. Also there are two temporary and one permanent premium stabilization programs that should reduce the benefits to insurers of cherry picking.

The private insurance market reforms were supposed to be accompanied with Medicaid expansions covering all adults up to 138 percent of the poverty level. The Medicaid expansion was, of course, invalidated by the Supreme Court and it looks like now that only half the states will expand Medicaid initially. When Medicaid was initially implemented, it took several years

for all of the states to sign up, and I expect that is what will happen this time as well. The federal government will fund 100 percent of the expansion for the first 3 years, phasing down to 90 percent over 6 years, but most studies have found that the states will come out ahead financially from the expansion. In states that resist the expansion, we will see the unfortunate situation of individuals with incomes above 100 percent of poverty receiving generous help but people with incomes below 100 percent getting nothing. They will have to be picked up, as now, by emergency rooms, free clinics, and federally qualified health centers.

How does law address other two foundations of system—doctor, hospital and disease centered care and fee for service payments?

Private insurance reforms are at heart of the ACA. Title I is the longest title of the legislation, but only one title in 10. Medicaid is a second title, and does not cover only the expansion of adult eligibility, but also the expansion of community care options, improvement of coordination of care for dual eligibles, and other changes. But the ACA contains eight other titles, dealing with quality, prevention, public health, workforce reform, transparency and program integrity, generic biologics, and many other topics.

Changes in the doctor, hospital, and acute disease centered system were already occurring before the ACA and would have continued without it. Doctors have been moving from sole practice to group practice for some time and from small groups to larger groups. Doctors have also increasingly been employed by hospitals and other providers and payers. We have also seen an increasing reliance on nurse practitioners, physicians' assistants, and even pharmacists to deliver preventive and primary care. The scope of practice of these practitioners is expanding; physician supervision is diminishing.

The ACA poses few direct challenges to our doctor- and hospital-centered system. It prohibits insurers from discriminating in allowing participation by providers acting within their scope of licensed practice. It prohibits Medicare payment for new physician-owned hospitals after 2010 and limits expansion of existing facilities. The emphasis of the ACA on patient-centered care medical homes will increase the use of non-physician health professionals in healthcare teams.

But the ACA will also have significant indirect effects. The demand for primary care that will be driven by millions of new enrollees in health insurance and the reluctance of doctors to engage in primary care practice would seem almost inevitably to move primary care away from physicians to other professionals. The competitive pressure that the ACA puts on insurance companies will drive them to narrower networks, reducing the bargaining power of "must have" imperial hospitals. The publication of hospital cost information may empower patients to make purchasing choices based on quality and cost rather than simply being at the mercy of whatever hospital they happen to end up at.

The legislation also has a major emphasis on prevention. The law expands wellness programs in the group market and includes, a demonstration project for wellness programs in the individual market, incentives for insurers to engage in prevention and wellness activities (such as nurse call programs), a mandate for coverage of preventive services without cost-sharing,

expanded preventive services in Medicare and Medicaid, a community prevention fund that could be used for projects such as bike paths, and a requirement that chain restaurants and vending machines display the nutritional content of their products.

The ACA also focuses on care for chronic diseases. The patient-centered medical home, accountable care organization, many of the proposals for the Medicare and Medicaid innovation center, a number of new programs to encourage community based rather than institutional long term care—all of these are in part efforts to address chronic diseases more effectively. Most of these programs are implemented through changes in Medicare and Medicaid, but private health insurers seem to be following the lead of the public programs, and indeed innovating on their own.

The third foundation of our health care system has been fee-for-service, charge-based payment. Here changes have been underway for some time. We have always had prepaid medical plans and capitation became fairly common in the 1990s. There have always been some physicians on salary, and salaried physicians have become more common as hospital employment has become more common. Medicare payment for institutional services moved almost entirely into prospective payment starting with DRG-RBS in the 1980s, although prospective payment is still a means of paying per case rather than per patient. There has also been a move toward pay for performance for at least a decade now, starting with demonstration projects and small add-ons but moving into the main stream.

The Medicare shared-savings, Accountable Care Organization program is a further move in this direction. It is an attempt to get doctors and hospitals to work together to save money for patients, with the providers and professionals sharing some of the risk and the savings. The Medicare and Medicaid Innovation Center is even more important, with a mandate and substantial authority to engage in experiments to improve approaches to provider payment. The Center has proposed about 40 demonstration projects for different projects for paying for health care. There is a continued movement on both the public and private side toward paying for outcomes rather than procedures, although we have far to go to learn how to do this.

The Moral Challenges Change Presents

What moral challenges do these changes present? First, the **change from a risk-based, market-based health insurance system** represents a real challenge. Our current system is based on a vision of actuarial fairness, and of the fairness and efficiency of markets. Healthy people ought to pay less for insurance, because they cost less. Wealthier people ought to have better access to coverage—they have earned it.

The ACA view of fairness is based on a **vision of shared responsibility**. Fairness means everyone is included—insurance costs more for the healthy and the young, but is available and affordable to older and less healthy individuals and families. Everyone is responsible for purchasing insurance if it is affordable, and large employers are responsible for covering their employees. The wealthy will pay more in Medicare taxes, which now cover, for example, investment income for those earning a quarter of a million dollars a year and more, and for health insurance. But insurance, and health care, will be more affordable to the poor.

All of this is coupled, of course, with expansion of wellness programs, higher premiums for smokers, and high cost sharing for most Americans, so this is not simply free care for all and subsidization of those who in fact refuse to be responsible for their health. But the idea of community responsibility is at the core of the legislation, and it runs counter to American individualism. This is one of the main drivers of opposition to reform.

A closely related challenge is **caring for those who have previously been closed out of the system and will now have access**. There will in particular be a demand for primary care that will be difficult to meet with our current resources. I am often asked the question, what will happen to those of us who are already in the system if millions of new people enter it. The basic answer is that we will have to share, an answer that should not be new or difficult for Christians.

But **primary care practitioners face a huge challenge**. And in particular the challenge is going to be caring for Medicaid recipients in states that expand their programs. The ACA attempts to meet this challenge. Congress appropriated $11 billion to expand the community health center program. It increases payment for primary care practitioners to 100% of Medicare with 100% federal funding, although only for two years. The ACA also established a 10% bonus payment for primary care physicians in Medicare for the years 2011 to 2105. There are also a host of programs in the ACA for expanding the workforce, including reallocation of residencies, scholarships, faculty support, continuing education support, loan repayment, and other support programs with a focus on primary care, geriatric and pediatric care, nursing, dental care, minorities, and rural areas.

Bringing millions into the health care system will nonetheless stretch resources and require that they be used more appropriately. This could mean less personal contact with patients with routine medical problems and more use of email and telephone. Very likely, it will mean more use of retail clinics to handle routine problems. It will require willingness on the part of doctors to yield control to some extent, to be part of a team.

It will also require willingness on the part of nurses, physician assistants, and others to take on more responsibility. It will also, most importantly, require willingness on the part of patients to understand that personal contact with a physician is not necessary to address every problem. And, regulators and the courts need to adjust to the new realities of patient care.

Changes in payment will create incentives to do less rather than to do more. This is a good thing if it eliminates wasteful and duplicative services. It is not if it skimps on necessary care. Much of the pressure to do less is likely to come from patients, who are facing ever higher cost sharing. There will be a temptation for doctors and other health care providers to simply insist on payment up front for services. It would be a terrible shame if higher cost sharing simply meant increased credit card debt, or even, in some cases, home equity loans to cover needed medical services.

One innovation that is likely to be helpful is the expansion of shared decision-making technology, where patients are given more information to make smarter decisions, and which often result in patients choosing less rather than more.

Finally, **the financial implications of reforms to providers are going to be significant**. Health care costs are the reverse side of income and profits. If you reduce costs, you also reduce income and profits. We have reduced costs in the past few years. We have seen the slowest growth in half a century in health care costs in the past three years. But much of the slowed growth has been because people have lost their jobs and insurance, and have been consuming less health care because they are uninsured or have high cost sharing. A number of studies have shown that higher cost sharing results in unfilled prescriptions or splitting pills and less preventive care.

We are coming to the end of a time that spans much of the lifetime of most of us living today when the resources available for health care in the United States were essentially unlimited. Practitioners and providers could charge whatever they wanted, insurers would pay and raise their premiums, and employers would pay whatever they were charged by the insurers. But millions of Americans were left out, and their ranks grew every year as employers dropped insurance in the face of increased costs.

These times are coming to an end, in part, but not entirely because of the ACA. The challenge is how to respond to a world in which more people have access to health care but we are not willing to spend more on it. I think we as Mennonites know something about service to the least of these and of doing more with less. I think we have an opportunity here to lead and teach, and hope we rise to the occasion.

***Timothy Stoltzfus Jost, J.D.**, Harrisonburg, Virginia, holds the Robert L. Willett Family Professorship of Law at the Washington and Lee University School of Law. He is a co-author of a casebook, Health Law, used widely throughout the United States in teaching health law and now in its sixth edition. He has written numerous monographs on legal issues in health care reform for national organizations and blogs regularly for Health Affairs, where he is a contributing editor, on health reform implementation. He is a consumer representative to the National Association of Insurance Commissioners, a member of the Institute of Medicine, and a member of the Community Mennonite Church in Harrisonburg.*

Moral Dilemmas and Choices

Editorial by Paul D. Leichty, M.Div.
Executive Director of Mennonite Healthcare Fellowship

As I've reflected on the theme and presentations of the 2013 MHF Annual Gathering, I have recognized anew that resolving moral dilemmas involves choices. At a very basic personal level, I hope that my choices reflect my Christian values. Jesus summarized those values as loving God and loving my neighbor as myself.

Yet, in today's global village where my actions can have a ripple effect on many people who I don't even know and will never meet or even see, how does one love the neighbor as oneself? Sometimes, even the choices that I make may benefit one neighbor but not another. Sometimes the short-term help I give to a few persons right in front of me has unforeseen but negative long-term consequences for many people, both seen and unseen. Were all of those antibiotics prescribed really necessary now that we know the increasing resistance being developed to those antibiotics? Have increased mammograms really prevented deaths from breast cancer in ways that other techniques could not? Is the skyrocketing use of Ritalin and other mind-altering drugs really giving us happier and more well-adjusted children?

Perhaps one place to begin resolving the moral dilemmas in our lives and our society is to ask, **"Who actually benefits by our choices?"** Here are some possibilities:

Myself. Jesus did say to love my neighbor as myself, so I could logically conclude that a choice that benefits me personally should benefit others as well. While that does appear to be the reasoning behind the growing libertarian movement in the U.S. (most notably, the "Tea Party,") most Christians would find that reasoning shallow and hollow.

The group to which I belong. Sometimes we extend ourselves by citing the benefits of our choices to a group—usually a favorite group, a group to which we have the most loyalty. That group may be as small as my family but is usually larger. It may be a professional group, a national group, a political party, or even a church group. It may be a group to which I belong because of a particular challenge that I face personally or in my family, such as cancer or AIDS, or intellectual disabilities. In a capitalist political system, groups form lobbies to advocate for public choices that benefit their group. However, the increasing problem is that choices that benefit one group work are detrimental to another group.

The persons who most deserve it. In deciding for one group over against another, we sometimes make choices according to some system of merit. In this way of thinking, there are those who have made poor decisions and need to live (or die) with the consequences, and there are others who suffer through no fault of their own. So choices are made in favor of the latter group. The problem comes about in determining the criteria for who deserves the help of others. Do people who smoke deserve treatment for lung cancer? Do people who don't eat healthy foods or don't exercise enough deserve treatment for high blood pressure and heart disease? Do both the mothers who drink alcohol or do drugs during their pregnancy as well as their babies deserve pre-natal care and neo-natal care?

The most people. Sometimes, we lay aside our moral criteria for who deserves our help and simply say, "I want my choices to benefit the most people, hopefully, the vast majority." While this may be a helpful criteria for resolving many moral dilemmas, it may also have the effect of catering to the group with the most power, the loudest voice, or those who claim most

forcefully to represent the will of "the people." Being in the majority doesn't automatically make us morally pure. Sometimes the majority who benefit by our choices aren't always those who need more benefits.

Those who are most needy. Many Christians would note Jesus' response to the question, "Who is my neighbor?" We usually call the story "The Good Samaritan." It illustrates that the neighbor is the one that you become aware of who is in need. This reasoning would call on Christians to make choices that offer the greatest benefits to the most vulnerable in society (those who are poor, who are sick, who have disabilities, or who are weak). The Biblical story indicates that the moral and spiritual health of the people of God was dependent on how they treated the widow, the orphan, and the stranger—those who were most vulnerable in society. Jesus indicates in the parable of the sheep and the goats that nations themselves will be judged by their treatment of the hungry, thirsty, the sick, and those in prison.

While all of these criteria may have something to offer in helping us resolve moral dilemmas, the Biblical record, and indeed, the life of Jesus himself, weigh heavily on making decisions that offer most benefits to those with the most needs. When Jesus was questioned on his own choices in how he spent his time, he used healthcare imagery to make the point clear: "Those who are well have no need of a physician, but those who are sick." God comes to us most fully at our point of need. While that may not totally resolve all moral dilemmas, it gives a clear starting point to make choices each day.

Paul Leichty is an ordained minister in Mennonite Church USA and Executive Director of MHF. He has also served in past and present roles as pastor, music minister, disabilities advocate, and computer support specialist.

Pioneer Mennonite Physician Dies in Paraguay

Paul D. Leichty, editor, *Mennonite Health Journal*

This article was prepared by Paul Leichty using sources in Spanish, German, and English supplied by Ingrid Kaethler Epp. In addition to the main article in the format of an obituary, there is an English-language version of Hans Epp's own life summary and testimony. Translation of German sources to English was graciously supplied by Gerhard and Rosemary Wyse Reimer of Goshen, Indiana.

Hans Edgard Epp, MD, died July 1, 2013 in Filadelfia, Paraguay, following a career as physician, public health official, family counselor, missionary, and educator.

Hans Epp was born in the Fernheim Colony in Paraguay on June 3, 1936 in the midst of the early years of poverty and difficulties in establishing the colony of German-speaking Mennonites fleeing Stalinist Russia.

At age 14, Hans had the opportunity to study in the Paraguayan capital of Asunción, completing his secondary level education in 1954. This qualified him to be a teacher in the school system back in Fernheim where he taught grade school from 1955 to 1957. During the summers, he prepared for medical school and returned to Asunción in 1958, studying at the National University where he graduated in December 1963 at the top of his class with the degree of "Doctor en Medicina."

Following a year of medical internship in 1964 at several different places in Paraguay, Dr. Epp continued his medical training in the United States, doing an internship and residency in surgery in Detroit, Michigan from 1965 to 1968.

During that time, a mutual friend introduced Hans again to Ingrid Kaethler, a Paraguayan Mennonite student at Goshen College in Goshen, Indiana. They were married at the Goshen Biblical Seminary Chapel on July 16, 1967. Ingrid survives, along with two children, a son, Mario Lotar Epp, and a daughter, Carmen Gloria Epp, as well as two granddaughters, Bibiana Beatriz Epp and Yazmin Yeruti Epp.

After Hans completed his medical residency in Detroit, the Epps returned to their homeland in the Paraguayan Chaco where Dr. Epp began his medical career in the Fernheim Colony capital of Filadelfia. By this time, Germanic Mennonites were already reaching out to their indigenous neighbors among the various tribes of the region. In 1968, Hans Epp was instrumental in founding a health program among the indigenous peoples of the Central Chaco, leading the effort to improve the public health of the region for more than twelve years. During this period of time, he took a leave of absence during the 1972-1973 academic year to pursue a Masters in Public Health at Harvard University in Boston, Massachusetts.

Wilmar Stahl, in a tribute on behalf of the larger umbrella organization known as ASCIM (La Asociación de Servicios de Cooperación Indígena-Mennonita), noted that the early public health

challenges Dr. Epp faced were the rapidly advancing tuberculosis and the unbalanced diet among children of the region. Stahl noted that after ten years, new cases of tuberculosis were reduced by 62% and mortality from tuberculosis fell by 73%. Epp trained teams of health promoters and nurses who moved to the indigenous villages to provide maternal/infant health services including talks in the native languages on practical public health matters such as hygiene and nutrition. (Stahl, 2012)

After years of recognizing the growing need for mental health services, Hans Epp marked a turning point in his career in 1981. Returning once again to the U.S., he did special studies at AMBS (now Anabaptist Mennonite Biblical Seminary) and Oaklawn Psychiatric Center in Elkhart, Indiana as well as Prairie View Mental Health Center in Newton, Kansas. He then served for the next ten years at the Eirene Mental Health Sanatorium in Filadelfia.

By the first of the year in 1991, Hans and Ingrid were sensing a call to work with a group of conservative Mennonites who had moved from Mexico to eastern Paraguay. After a transition year, the Epps moved from Filadefia to Asunción in 1992 where Hans established a private practice in family counseling and pastoral care but spent most of his time working with the "Mexican Mennonites." During these years, Hans also taught a course in counseling at the Mennonite seminary in Asunción, collaborated in a translation project of the Low German Bible for the Old Colony Mennonites in Latin America, and, along with Ingrid and several other couples, helped to plant a new Spanish-speaking congregation.

In July 2000, they terminated the work with the Mexican Mennonites and in January 2007 returned to Filadelfia, spending their remaining years with their extended family which included two grandchildren. As Hans Epp recognized that his battle with liver cancer was coming to an end, he reflected on his life with a combination of gratitude to God and a ringing faith that called on family and friends to recognize God's love for everyone. As a man with superb intellect, vast vision, command of three languages, and a servant's heart, Hans Epp was able to use his professional skills in medicine to minister to body, mind, and spirit in unique ways to many people across many cultures. Following are his final reflections in anticipation of his death.

Obituary

Hans Edgard Epp (June 3, 1936—July 1, 2013)

I was born at home in Karlsruhe, village number 16 in Fernheim, the third of six children. My parents were Johann Epp and Katharina Epp, née Ratzlaff. That was in the difficult beginning years of the colony. In spite of the poverty and difficulties, I developed quite normally, for God had laid me in the cradle with a strong will to live.

Growing up in a pious God-fearing family, it happened that during our nightly prayers, already as a small child, I invited and accepted the dear Lord into my heart and my life. I took it in a very child-like way. Never in my life have I had to question the existence of God or Jesus' boundless love for me. There, in infancy, began my conscious life as a child of God.

When I was nine and a half years old, at the first summer Bible school held in Fernheim, we children were invited to experience conversion. I asked what that meant: To confess my sins, to ask for forgiveness, and to invite Jesus Christ into my life. Thereupon I said, "I've already experienced all that long ago." The somewhat baffled teacher replied: "You have to know the exact day and hour when you did this. It would probably be better if you would do it publicly tonight." So December 12, 1945 is the date of my official pro forma conversion, a ritual with profound meaning for me on my way to adulthood. Afterwards, at home, my parents explained the meaning of this ritual to me and my brother and nailed it down in my consciousness that from this time on I am a child of God and that I will remain a child of God as long as I live, no matter what Satan or other people may tell me. This assurance has remained fixed within me.

While the frequently sung Sunday school songs of that era nourished my child-like faith, in later years my knowledge of God grew in height, breadth, and depth. Based on the clear understanding of the redemptive work of Jesus Christ, at the age of sixteen I was baptized in the Fernheim Mennonite Church. Since that time I have worked in various capacities in congregations and mission. During the many changes of residence in our life, my wife Ingrid and I have always carried our church letters to the respective congregations; in our last segment we now have returned to the Fernheim Mennonite Church.

At age fourteen I had the unique opportunity to study in Asunción, unusual for that time, and I accepted eagerly. First I completed teacher training and a few years later I returned to study to become a medical doctor. Later during my studies in the USA, I learned to know a Paraguayan student, Ingrid Kaethler, a treasure trove indeed. On July 16, 1967 we were married in Goshen, Indiana, USA. A year later we returned to the Paraguayan Chaco, our home.

This is where our two children, Mario Lotar and Carmen Gloria, were born.

During my years of work, God has led me on paths I would never have dreamed of myself. These paths, however, say a lot about the great will of God; and he has led me well. In a period of twelve years, I was able to develop a health program for and with the indigenous people of the central Chaco. This program continues to function and grow. Both I and my wife (my able assistant) embraced these people in our hearts; God simply gave both of us a great love for them.

God's calling for my life led me to further study in the USA and from there to my next field of work: the work of Servicio Menonita de Salud Mental, Sanatorium Eirene. For a period of ten years I was able to serve a different group of people: those suffering emotionally, mentally and spiritually, those for whom society often has little understanding. My love for these people helped me to see a great potential in them.

Through this work God brought me in contact with very conservative Mennonites who came to East Paraguay from Mexico. In 1991 my wife and I sensed a very clear call to venture out and undertake full-time work with these brothers and sisters. It was a highly momentous faith venture. We moved to Asunción where for nine and a half years our main commitment was to the conservative Mennonites in East Paraguay. We were able to scatter many seeds and initiate positive changes. We were loved by many, but we also experienced some hostility. These

congregations have not remained the same. In many places we see various kinds of fruit. During these years I also collaborated in the translation of the Low German Bible for the Old Colony Mennonites in Latin America.

In the meantime I had developed a private practice in family counseling and was deeply involved in the Concordia congregation and in mission. For many years I also taught a course in counseling at CEMTA, the Mennonite seminary in Asunción, and served as administrator for the German section of the so-called Family Services Worldwide (Familiendienste Weltweit) and translated and/or developed basic courses in marriage, family and spiritual formation. At the same time, with a few other married couples from the Concordia Mennonite congregation, we helped to form a Spanish- speaking congregation based on the apostolic example, which gave us much joy.

At the age of 70, we moved back to Filadelfia.

My experience with the cancer of the liver introduces the final chapter of my life.

I would like to place the following upon the hearts of my friends, brothers and sisters: Free yourselves of all anxieties and fears that God will abandon you. God does not do that! Trust God! Start listening to Him! God wants you to follow Him! Do not run ahead of Him! Do not run away from Him! Obey and trust! If you cannot do this, maybe the image of God's true being has not yet penetrated you completely! God loves you, precisely you! God also loves everyone in our marginal groups, including those from a broken family! And each of you has been called to be the bearer of God's love to the marginalized. God also loves every indigenous person and all who have migrated into our midst the same way he loves you. I also rejoice in the fact that God loves me in such a way that I can have a relationship of love with him and with all those who surround me. And thus I can say farewell to this world.

The bereaved family:
Spouse: Ingrid Epp, née Kaethler
Son: Mario Lotar Epp; daughter: Carmen Gloria Epp
Granddaughters: Bibiana Beatriz Epp and Yazmin Yeruti Epp

Works Cited

Stahl, W. (2012, July 3). *Dr. Hans E. Epp: Fundador del Programa Pro Salud Indígena de la ASCIM*. Retrieved from ASCIM: http://www.ascim.org/?Noticias_breves:Julio_2013

Mungindu: A poor but thriving community in Congo

By Murray Nickel, President, International Mennonite Health Association

We all know that that the Congolese lack a lot of things--adequate healthcare, effective education, a promising economy, sufficient infrastructure, even reliable peace. It doesn't take years of study to recognize the needs in Congo. Poverty stares you in the face the moment you get off the plane. Since I graduated from medical school I've been asking the question, "What do the poor need?" Is it money or resources? Or is it skills? Probably. But none of these things seem to leave a lasting effect. It has dawned on me that the question I've been asking is all wrong. Let me explain.

Last November, I met briefly with Jean-Pierre, a school headmaster and supervisor of about sixty Mennonite schools in the area. I remember it clearly. We stood outside conversing, struggling to catch some shade from the burning Congolese sun. It wasn't a long conversation. He asked me what it would take to get a teacher's conference organized. I was fairly blunt. Organizing an event like that would be Jean-Pierre's dilemma, not mine.

But I did have a teacher friend, Mike, that I thought might be interested in raising a little money and possibly coming out next March. Jean-Pierre pressed further saying they had no resource books for teachers. I responded that maybe Mike could find a few books. But where would they keep them? They'd need a building to protect them.

That was it, a brief conversation. Four months later I found myself walking through the countryside to Mungindu with Mike, Jean-Pierre, and a few others.

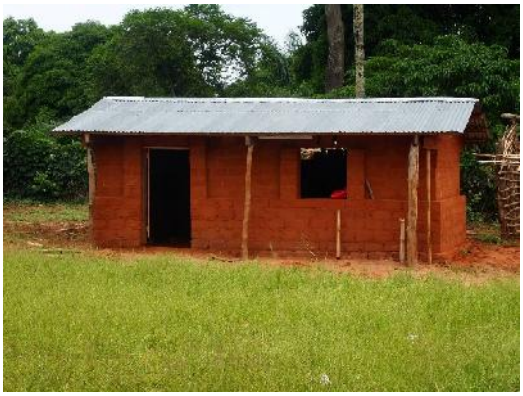
Traveling in Congo is painful, slow and expensive. Interior roads, if you can call them that, are no more than long lines of chewed up sand and mud haphazardly laid through the grasslands and cut through the forests to connect one village to another. Deep ruts and washouts make descending into valleys a navigating challenge to avoid tipping over. Breakdowns are common. Sure enough, an hour later, twenty kilometers into the trip, we joined the statistics of broken down vehicles on the road. The back wheel had come off. So we picked up our packs and started to walk.

Walking in rural Congo is nothing like driving. It's slower, no doubt, but it also provided us opportunities we wouldn't have had otherwise. We may feel alone in a vehicle, but we didn't when we were walking. We passed numerous bicycles rigged with draw-strings guidance system and laden with sacks of manioc being pushed through the sand to market. Glistening with sweat, the bikers took time to be friendly, offering a brief greeting between puffs. We also get much wetter

walking in Congo. If it's not the sweat, then it will be the torrential rain. However, in Congo, rain can be most refreshing. The darkness settles in quickly making it hard to see. Yet that too forced us to stop and visit with the people that we meet. When we walked, we found that village people, wherever we went, fed us and offered a place to sleep. After two long days, we finally crossed the Kwilu River and walked up the hill to Mungindu. Tired and hungry, we were obligated to visit before being fed and provided a place to sleep.

I got up just after daybreak. Jean-Pierre was already busily getting things organized for the teacher's conference. His anxiety was palpable despite the brave face he put on. Over sixty headmasters, and several other teachers, had walked to Mungindu for the event. The village was buzzing with expectation. But the food he had prepared for the event was delayed; it was stuck in Kikwit. Not only that, the trainers for the event had not arrived either. The only means of communicating with Kikwit was by shortwave radio, and this was more than unreliable.

Jean-Pierre was in the dark. The proceedings couldn't start without supplies and food, let alone the trainers. The local church responded generously. They kicked in their support and whipped up a hundred or so servings of fufu and greens. By the time the trainers and food arrived, the sun had gone down. In the light of the full moon and with our hunger satisfied we sat down to listen to new arrivals' harrowing stories of repairing, jimmying, pushing, waiting, searching and finally arriving in Mungindu.



Waiting around meant I had time to visit the hospital and some of the local projects as well as get to know Jean-Pierre. I learned that the local Minister of Parliament had gotten excited about the conference and had sponsored the construction of a large classroom that could hold up to 200 people in a pinch. He purchased the tin and the wood while the parents of the students supplied the manpower. With the leftover materials, the parents and teachers constructed a two-room building to serve as a library. The doors and windows still needed to be placed but it was essentially finished. It's amazing what even a poor rural community can pull together in two months!

The next day the teacher's conference began. The trainers were excellent. The elementary school trainers broke up their lectures with songs and games, techniques the teachers could use in their classrooms. The secondary school trainer carefully went through the math curriculum all the while interacting with and engaging his listeners. He told me later that he had spent several years in

France completing his masters before coming back to Kikwit to teach at the university. Mike, for his part, observed, interviewed teachers on camera, and experimented with technology. He had brought with him e-books and videos on a Kindle pad.

Unfortunately, I had to leave the next day. I left Mike behind. As expected, the rented vehicle broke down on the way back to Kikwit. But as I sat there in the hot sun waiting for the chauffeur to tie the wheel back onto the axle with a piece of rope, I reflected on my experience. What had my contribution been here? Mungindu is a typical poor Congolese community, yet they found resources in their red clay to make bricks, money from a local official for wood and tin, hard work from parents, local cooks with access to local food through the church, teaching expertise from a nearby urban center, and a group of headmasters that were hungry to learn.

What then is the question we should be asking? No doubt, the poor need money and resources. And we, the non-poor, have a responsibility to contribute. But more importantly, they need hope and encouragement. They need to see that solutions are essentially already there, within their own communities. Local initiative and drive are indispensable. They are more important than the resources a white foreigner, like me or Mike, can bring. Every community has assets and these assets are the essential building blocks for community transformation. The question then is not, "What do you need?" but rather, "What do you have?"

Murray Nickel
Murray is an emergency doctor in Abbotsford, BC. He is president of the International Mennonite Health Association (http://www.intermenno.net/) and he consults for Mennonite Brethren Missions.