



## History lessons: Local organizations can provide care for the poor

### Executive Summary

Throughout much of American history, charitable giving and local aid societies were the vehicles through which the poor and underprivileged were helped. These community-oriented systems were respected, proven ways of distributing services to a broad spectrum of people with a variety of needs.

Local groups that provide unique, focused support to help the poor, most especially health care, can be the path forward again, not just in Idaho, but also in other states. Policymakers should consider fostering the growth of voluntary, private organizations to help lift people out of poverty, connect individuals with doctors and clinics, and help the poor save for emergencies.

To help those in need obtain health care, instead of expanding a federal program such as Medicaid, the state of Idaho could:

- Expand the use of Individual Development Accounts, to allow more Idahoans to work with partner organizations to save for a health care emergency.
- Provide individual taxpayers with the option of donating their Grocery Tax Credit toward health-related programs.
- Allow taxpayers to direct some or all of their income tax refund to be used by those in need for their health care purposes.
- Utilize the state Millennium Income Fund as a source of revenue, to help match monies raised by local organizations, to finance insurance premiums and other health-related programs for poor and low-income people.
- Re-direct state catastrophic health care monies toward privately-funded and -operated health care programs, as described in this paper. The use of general taxpayer support should be just long enough for the volunteer sector to again find its footing and establish long-term, non-governmental health care programs that benefit people of limited means.

### A history of caring

Alexis de Tocqueville, a Frenchman who visited the United States in the 1830s, took special note of American philanthropy and its critical role in helping to make the country a rising star long before it became a world superpower. In his two-volume book, "Democracy in America," de Tocqueville noted that American charitable organizations (described in his lexicon as "associations") were successful at filling societal needs:

In the United States, as soon as several inhabitants have taken an opinion or an idea they wish to promote in society, they seek each other out and unite together once they have

made contact. From that moment, they are no longer isolated but have become a power seen from afar whose activities serve as an example and whose words are heeded.<sup>1</sup>

To understand this fully, one must realize that many of society's maladies were addressed by private, voluntary community organizations and not the government. People came together to create organizations, and those organizations united to form hospitals, run orphanages, feed and clothe the homeless and the hungry, and so on. The organizations — fraternal benefit societies (also known as lodges or mutual aid societies) and charities — bestowed upon their members many practical resources to fight poverty, provide job and leadership training, and advance good character.<sup>2</sup>

The United States was not the originator of such arrangements. "Friendly society" organizations had cemented themselves in Britain as "the most important providers of social welfare during the nineteenth and early twentieth centuries."<sup>3</sup> In the American colonies, the Freemasons organized a lodge in Boston in 1733.<sup>4</sup> Those lodges spread throughout the eastern seaboard, bringing in new members from across the socioeconomic spectrum. Odd Fellows, Foresters and other groups followed. At first offering charity, the groups later added other benefits as part of their membership.

As the years rolled on, more organizations provided support in the event of economic hardship or illness. Fraternal societies, or lodges, became vital in promoting the wellbeing of Americans. Men and women paid to belong to a lodge, in sickness and in health, and they benefited from that membership. As such, the use of medical care through a lodge was commonplace. "Lodge doctors" were elected to provide care to the membership. In 1915, the New York City health commissioner noted that many of its residents had chosen lodges as the primary mechanism for helping the poor.<sup>5</sup>

History professor David Beito notes that fraternal organizations experienced a decline in the early 20<sup>th</sup> century, which may be attributed to the rise of the modern welfare state. A specific factor in the decline of fraternal organizations was the lobbying of medical associations, which sought to "organize medicine to improve its fortunes by increasing its professionalism and reducing its numbers, thereby raising their income."<sup>6</sup> This effort worked too well.

Health care researcher Greg Scandlen wrote, "The newly powerful voices of organized medicine went to work to end the practice of lodge medicine. They objected to the idea that common workmen could be their bosses and that competing for lodge contracts on an annual basis depressed their incomes." He added, "They decided to drum out lodge physicians from the profession."<sup>7</sup>

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<sup>1</sup> Tocqueville, Alexis de, Harvey C. Mansfield, and Delba Winthrop. 2000. *Democracy in America*. Chicago: University of Chicago Press.

<sup>2</sup> David Beito, "From Mutual Aid to Welfare State: How Fraternal Societies Fought Poverty and Taught Character," The Heritage Foundation, <http://www.heritage.org/research/lecture/from-mutual-aid-to-welfare-state>.

<sup>3</sup> David Green, *Reinventing Civil Society: The Rediscovery of Welfare Without Politics*, 1993.

<sup>4</sup> David Beito, *From Mutual Aid to the Welfare State*, University of North Carolina Press, Chapel Hill, 2005.

<sup>5</sup> *Ibid.*

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

Few know the role lodges played not so long ago in providing for the welfare of the poor and needy. Writes Beito:

When many of us hear the word lodge, we think of it as a place where television characters from our youth, such as Ralph Kramden (of the Loyal Order of Raccoons) and Fred Flintstone (of the Loyal Order of Water Buffalos), escaped from their more sensible wives to engage in childish hijinks—parading around with silly hats and mouthing pretentious rituals.

There was a time, however, when fraternal societies could not be so easily dismissed. Before the rise of the welfare state, they were rivaled only by churches as organizational providers of social welfare. By conservative estimates eighteen million American men and women were members in 1920 at least three out of every ten adult males. While fraternal societies differed in ethnicity, class, and gender, most shared a common set of characteristics. In general, this included a decentralized lodge system, some sort of ritual, and the payment of cash benefits in times of sickness and death.<sup>8</sup>

In 1914, Robert Allen, a doctor for the A.C. White Lumber Company of Idaho, wrote, like some European nations, it was “only a matter of time [before] we will also have state insurance against sickness.”<sup>9</sup> Allen’s prediction started to come true in the 1960s with the creation of Medicaid and Medicare, and later with the passage of the Affordable Care Act (ACA) in 2010. Among other things, the ACA mandates insurance coverage for all Americans.

Today, low-income Americans, excluding seniors (who are on Medicare), may fall in one of three categories: those who are on Medicaid, those who qualify for government-provided insurance subsidies, and those who neither qualify for Medicaid or insurance subsidies. Of the latter category, the Affordable Care Act mandates that states expand Medicaid to cover that population, which includes low-income, able-bodied childless adults.

### **Individual Development Accounts**

With health care and insurance costs on the rise, it is important to know the role non-governmental organizations once played in caring for people, and the role that such organizations continue to play (mainly outside of medicine) in helping people who need a helping hand. For example, liberals and conservatives have hailed the use of Individual Development Accounts (IDAs). These are savings accounts that can be used for specific, legally-defined purposes, which, as of now, do not include health care, but could.

Here’s how an individual development account generally works: A participating non-profit organization works with a client who has a predefined savings goal. For every dollar the client puts into the account, the non-profit matches the funds at some level, as high as 5:1. To receive the match and remain in the program, the client must abide by the program’s rules, which are set by each non-profit. Those rules may include, for example, participation in a financial management class, home economics or other

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<sup>8</sup> Beito, “Lodge Doctors and the Poor,” May 1, 1994. <https://fee.org/articles/lodge-doctors-and-the-poor/>

<sup>9</sup> Journal of the American Medical Association, Volume 63, 1914.

program tailored to that person's particular needs. Money in the account can only be disbursed by the client and non-profit working together.

IDAs enjoy broad support because they allow individuals and families to develop savings, which could mean the difference between economic prosperity or ruination. Says the Annie E. Casey Foundation, "Assets also can promote family stability, encourage political participation, and give people a stake in their communities."<sup>10</sup> Conservative organizations like the fact that IDAs require participation on the part of the client and that the savings goals and objectives are handled by a local organization, which works with the client, rather than a system that depends on government staffing and direction.

Nationally, research on Individual Development Accounts has found that program participants were 85 percent more likely to own a business and twice as likely to go on to college than a comparable group that did not use IDAs.<sup>11</sup>

Under Idaho law, an IDA can be used specifically for college savings, to buy a home or start a business.<sup>12</sup> Since 2005, 77 Idahoans have completed a program outside of the Boise Valley. This has helped 47 people to purchase a home, 25 to receive a post-secondary education and five to start a small business.<sup>13</sup>

In the Boise Valley, 33 people enrolled in the IDA; three withdrew. Of the remaining 30 participants, seven completed the program, allowing them to enter college or purchase a home. The remaining 23 continue to save toward home purchase and college education goals.<sup>14</sup>

Idaho law, at present, does not allow people to use IDA accounts for health-related purposes, though it could.<sup>15</sup> Additionally, such savings accounts could be augmented with matching dollars in order to dramatically boost the savings that could be used for health care expenses. One source, as noted above, is the Millennium Income Fund, which is used to allocate money from the 1990s settlement with tobacco companies. Another potential source is the state income-tax form; Idahoans who do not accept the tax credit associated with grocery purchases can voluntarily give that money to the state of Idaho. Currently, by law, the money can only be used for home energy assistance.<sup>16</sup> Last year, about \$300,000 was returned to the cooperative welfare fund for this purpose.<sup>17</sup> Idaho lawmakers could provide taxpayers with the option of utilizing the funds for health care costs, possibly matching the money put in by charities for IDA accounts.<sup>18</sup> Re-allocating general fund money from the catastrophic health program

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<sup>10</sup> Individual Development Accounts and Other Asset Tools, Annie E. Casey Foundation, August 2006.

<sup>11</sup> Assets for Independence Report to Congress, Oct. 11, 2012.

<sup>12</sup> Title 56, Chapter 11, Idaho Code.

<sup>13</sup> Data from the state Division of Financial Management (DFM). Another 89 dropped out of the program for non-compliance reasons. DFM is the designated agency to manage the program under state law. Non-compliance generally refers to a client's unwillingness to follow the program's self-improvement parameters. If a participant does not comply, she gets to keep the money she put into the account, but not the matching funds.

<sup>14</sup> Ibid.

<sup>15</sup> See proposed draft legislation from 2016.

<sup>16</sup> Idaho Code 63-3024A.

<sup>17</sup> Data from the state Tax Commission.

<sup>18</sup> See attached draft.

toward this program would also be a good, interim step to help cement support this market-based program.

### **Re-invigorating the volunteer sector**

An individual development account is just one tool being used by the “volunteer sector” — charities and related non-profit organizations — seeking to help people who are trying to elevate their economic stature. Government should look for opportunities that remove obstacles that hinder community organizations and allow non-profits and fraternal benefit associations to return to their historic role in providing for people in need. This could be accomplished by making matching grants available to organizations in order to build capacity and to leverage donor support for programs that benefit the poor.

For example, a fraternal benefit society may wish to pay for a portion of a person’s health insurance premiums. That organization may also want to allocate money for a direct primary care program, gym membership or savings in an Individual Development Account. How the programs are designed is entirely up to the charity or fraternal lodge. The state’s role is simply to help local organizations build a base of support through those matching grants. As such, it is recommended that the Legislature allow that these programs:

1. Be funded, to the degree possible, without new taxpayer support, e.g., the use of tobacco settlement money or monies voluntarily assigned to the program by a taxpayer, e.g., through the voluntary release of grocery-tax credit dollars. Another option is to redirect existing catastrophic health care money.
2. Use matching grants as opposed to outright allocations of money; the requirement that organizations develop their own base of support is critical if these programs are to be effective in the long term.
3. Be open to a wide range of providers; statutory language should be written so that a multitude of diverse organizations can participate and not geared toward one type of organization.
4. Be open to a wide range of services. Organizations should be able to choose whether enrollment in health insurance, direct primary care, gym memberships, health share ministries or other innovative arrangements would best meet the needs of a client.
5. Originate in the private sector. The Legislature need not create new entities to accomplish the task.
6. Allow the programs to operate in such a way that organizations are able to operate unfettered by new regulations, bureaucracies or addition of public employees.<sup>19</sup>
7. Should be limited in duration. Organizations should not expect or depend on government matching grants. Sunset clauses and a funding formula that reduces matching grant allocations over time would signal participating organizations that the need to develop local support is real.

To the degree possible, grants should follow the ability of organizations to build local support from donors, volunteers and health care practitioners. Doing so keeps the organizations accountable to their

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<sup>19</sup> It is understandable and foreseeable that some administrative overhead might be necessary, or that the disbursement of money from the state would require some level of monitoring. The focus should be on adding staff and regulations necessary to execute the ministerial and administrative responsibilities of this program, not to manage it or to direct non-governmental organizations in their activities.

donors and prevents the state from providing funding to programs that do not have popular support. In this fashion, there exists a free market system that rewards high-performing organizations that develop a strong donor base and direct money in a responsible way. Indeed, it is expected that this will mean organizations will have to build their cases for support, and some organizations will fail to do so. Meanwhile, others will flourish. This is preferable to the state simply allocating grants to organizations year after year, even if the organization fails to generate a clientele or a base of financial support within the community.

The table below presents an example of cost allocations for one hypothetical client. Bear in mind, the numbers would vary depending on the expectation of the client to contribute, the willingness and ability for an organization to match a client's contribution and available funding from the state.

Fund sources	Monthly cost	Annual cost
Client	\$ 10	\$ 120
Organization	\$ 50	\$ 600
State	\$ 150	\$ 1,800
Total	\$ 210	\$ 2,520

Such funding could, depending on the age, gender and health characteristics of the individual, provide more than enough money for a health insurance product. Or, the money could be used to purchase a direct primary-care membership and build savings as part of an Individual Development Account. The exact details would be worked out by the client and the participating non-profit, fraternal benefit society or similar organization.

There should be an objection to the idea of the government providing subsidies to help people buy a product. However, there are important considerations as to why this program may be a good idea, at least at this time. First, such a program could help unwind the state's single-payer health care system, known as the county indigent/catastrophic care program. Having local organizations with expertise in poverty and self-reliance is preferable to a system that relies on county commissioners and a state-funded program that merely pays health care bills.

Second, such a matching grant program — of limited time and scope — could help revitalize the private, voluntary programs that government bears some responsibility for having deconstructed. Indeed, if such a program were successful, it could demonstrate applicability in other areas where government has assumed the sole responsibility for the poor.

Also note that the concept behind this program differs from the one contained in the Affordable Care Act. Under the ACA, insurance subsidies are provided to the insurance buyer who falls within a certain income category and, therefore, is presumed to need help buying insurance. The subsidy contemplated here requires the financial participation of the client and a private organization before involvement by the government. The state plays a role in matching the money already raised.

Additionally, the heart of the Idaho proposal is that it is up to local organizations, not the government, to decide the best use for the money. The organizations are held accountable to their donors, who will have the task of validating the private organization's work on a recurring basis.

## Groups already offering help

If government refrains from crowding out competing enterprises that work with low-income people, it is reasonable to expect that non-profit organizations, fraternal benefit societies or other similar organizations may wish to step forward to provide insurance or other programs as a benefit to members. Some non-profit organizations are already helping fill a gap when it comes to assisting people buy insurance or accessing medical care.

In Seattle, Project Access Northwest has been working with low-income residents for ten years. The non-profit organization has a budget of about \$2 million and operates two programs, funded almost entirely by private donors.

The first program connects low-income, uninsured patients with specialty doctors. These doctors volunteer to offer their services to as few as two patients a month.<sup>20</sup> Other practitioners elect to serve even more patients. As a result, as many as 40 specialties are covered by some 1,600 doctors. Last year, the organization served 6,700 patients. Fewer than five percent of Project Access Northwest patients missed their appointments.<sup>21</sup>

Project Northwest Access also started a program that provides premium assistance support to clients who cannot afford insurance on their own. That program has thus far provided aid to 170 households and 202 people, according to Sallie Neillie, the organization's executive director. Neillie contends the program has been highly successful, providing a return-on-investment to the program's funders, the hospital system, by as much as four dollars for every dollar invested.<sup>22</sup>

## Conclusion

Americans have a rich history of caring for one another, particularly in times of health care crises. Until the rise of the modern welfare state, few people would have contemplated depending on a government program for help. Today, few people imagine a world where the poor are cared for by anyone except the government. Yet, consider what has happened to health care since the intervention of government: the rapid rise of health care costs, the rapid rise of insurance premiums, and the decline in quality and availability of health care professions. Rather than create a new government program, or expand a failing one like Medicaid, Idaho and other states would do well to look to the past for ideas about how to contain costs and improve the quality of care.

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<sup>20</sup> IFF interview with Sallie Neillie, executive director of Pacific Access Northwest, Aug. 23, 2016.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.