IDAHO FREEDOM FOUNDATION

Policy memo

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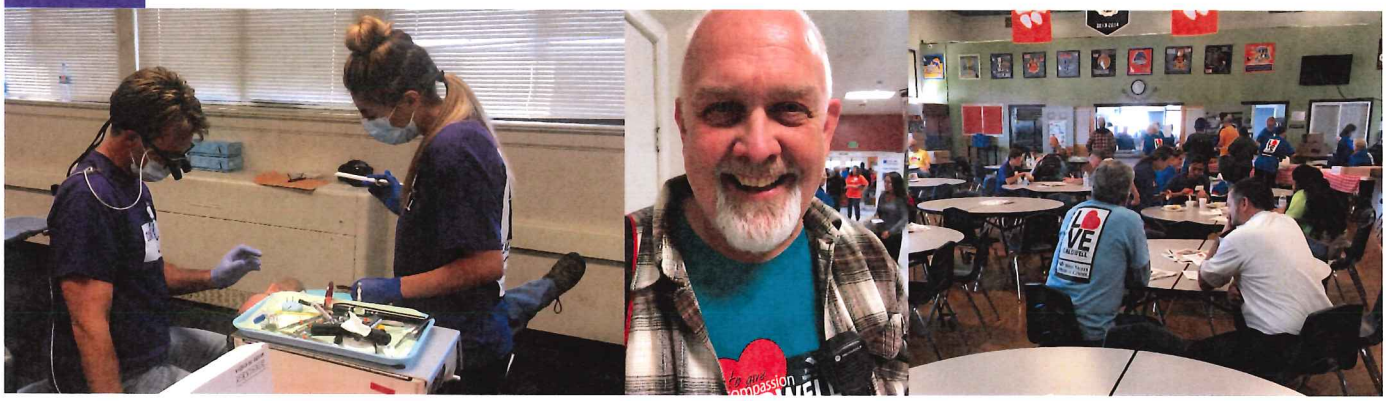
History lessons: Local organizations can provide care for the poor

By Wayne Hoffman, President



Executive summary

Throughout much of American history, charitable giving and local aid societies were the vehicles through which the poor and underprivileged have been 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 that are historically proven to help lift people out of poverty, help the poor save for emergencies, and connect individuals with doctors and clinics. At the same time, policymakers must understand that the government must not play a central role in the delivery of charitable services. The best role is to play no role at all.

To help those in need obtain health care, instead of expanding a federal program such as Medicaid, and instead of providing a state government-run solution, the state could allow volunteers and volunteerism, charity and community-based support, to work by choosing to:

Expand Idaho's charity-care liability immunity statute[1] to include physicians offering services for free from their own clinics, and to provide continuing education credits associated with such services.

Expand Idaho's statute governing Individual Development Accounts,[2] to allow the accounts to be used by Idahoans to save for a healthcare emergency.

Provide individual taxpayers with the option of donating their Grocery Tax Credit toward health-related programs for low-income individuals and families.

Allow taxpayers to direct some or all of their income tax refund to be used by those in need for their healthcare purposes.

Executive summary (continued)

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 healthcare monies toward privately-funded and -operated health care programs, as described in this paper. The use of general taxpayer support should be short-term and funding decisions be predicated on local support in the form of a financial match, as described later in this paper.

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 seminal 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.*[3]

To understand this fully, one must realize that many of American 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.[4]

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."[5] In the American colonies, the Freemasons organized a lodge in Boston in 1733.[6] 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.[7]

History professor David Beito notes that fraternal organizations experienced a decline in the early 20th 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."[8] This effort worked too well.

Healthcare researcher Greg Scandlen, an expert on healthcare financing and insurance regulation, 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

> Government aid programs, simply stated, have failed to deliver on their promises.

for lodge contracts on an annual basis depressed their incomes." He added, "They decided to drum out lodge physicians from the profession."[9]

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

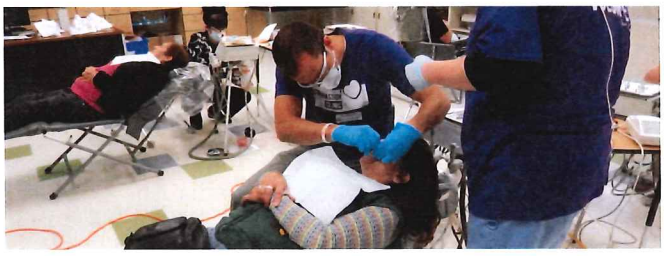
> When many of us hear the word lodge, we think of it as a place where television characters from our youth, such as Ralph Kramden (of the Loyal Order of Raccoons) and Fred Flintstone (of the Loyal Order of Water Buffalos), escaped from their more sensible wives to engage in childish hijinks—parading 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.[10]

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."[11] 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. The U.S. Supreme Court has ruled that such an expansion is optional, thus leading to the debate underway in Idaho and other states.

But government aid programs, simply stated, have failed to deliver on their promises, especially over the long term. Moreover, they cause people to become more dependent on government. Author and researcher James L. Payne notes that government tends to ignore the failures associated with handouts.

> Charity leaders of the nineteenth century had lived with the poor and had analyzed the effects of different kinds of aid. They discovered that almsgiving—that is, something for nothing—actually hurt the poor. First, it weakened them by undermining their motivation to improve themselves. If you kept giving a man food when he was hungry, you undermined his incentive to look for a way to feed himself. Second, handouts encouraged self-destructive vices by softening the natural penalties for irresponsible and socially harmful behavior. If you gave a man coal who had wasted his money on drink, you encouraged him to drink away next month's coal money, too. Finally, the nineteenth-century experts argued, handouts were self-defeating. People became dependent on them, and new recipients were attracted to them. So this type of aid could never reduce the size of the needy population. With handouts, the more you gave, the more you had to give.[12]



> A personal relationship between the person in need and the helper is the foundation of charity.

Payne argues that the best way to provide for the needy is to expect something of the recipient. Charity leaders prior to the rise of the welfare state understood the need to emphasize self-sufficiency. He wrote, the needy "weren't given money, but were counseled to find employment; they weren't given apartments, but were rented, at cost, healthy dwellings managed by charities; they weren't given food, but learned to grow their own food at garden clubs developed for that purpose."[13]

Getting charity right

Payne has written extensively on the need for volunteerism and community-based solutions rather than government coercion through taxation in the guise of charity. But not all charity is created equal. Through trial and error, Payne wrote in his book "Overcoming Welfare," charities figured out that successful gifts — the ones that lifted people from poverty rather than trapping people in it — had certain common characteristics:

A personal relationship between the person in need and the helper is the foundation of charity.

Sympathetic (something-for-nothing) giving is generally harmful to the needy.

Personal assistance should focus on the individual's future prospects, and therefore on his correctable personal shortcomings.

Effective helping elicits constructive action from the recipient.[14]

The reverse describes the trappings of government — a system that lacks personal connections, handouts with no expectation of contribution or action on the part of the participant, and no concern about what might inhibit their future. Payne writes further, accountability to the one paying the bill makes charities different than government in their success at helping individuals:

> [I]n any kind of organization based on voluntary donations, no matter how large, there is one ultimate check. If programs become too unattractive—if they are clearly seen to create dependency or to assist recipients who are not trying to help themselves—donors are free to stop contributing. In the end, notoriously bad programs will be cut back or terminated. … Programs based on the tax system—whether operated by government agencies or nonprofits using tax money—lack this safeguard. If donors are forced to give through the tax system, they cannot decline to support programs, no matter how much they disapprove of them.[15]

Said differently, charities live or die based on the blessing their supporters. If a charity fails to deliver the results expected by the donor, the donor stops giving and the charity goes away. While some may view this as a negative, it is, in fact, a blessing. Organizations come and go, and they're replaced by organizations that do better things or by organizations that do things better. Donors drive those decisions because their support is given freely, without coercion.

The same cannot be said for government. The government taxes individuals and then uses the revenue to fund programs. If the programs fail to produce the desired results, government uses its force to compel more money from individuals and puts more money into the programs. Usually, special interests and program dependents apply political pressure to keep the program in place, causing politicians to keep funding — and even increase funding — for programs that do not work.

The Legislature need not create new entities to accomplish the task.

However, taxpayer money is already being used to pay for healthcare programs that are too costly and fail to help people in need. This support should be phased out. During this phase out, any taxpayer money used for charitable purposes should matched to the money raised locally. Additionally, such programs should:

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 healthcare money.
2. 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.
3. 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.
4. Originate in the private sector. The Legislature need not create new entities to accomplish the task.
5. 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.[16]
6. Not expect or depend on government matching grants. Sunset clauses and a funding formula that reduces matching grant allocations over time would signal to participating organizations that the need to develop local support is real.

Individual Development Accounts and other matching programs

Rolling back government-run programs and allowing charity and other voluntary, private programs to take hold in their place will take time. There are examples, however, of programs that come from the private sector and have broad appeal.

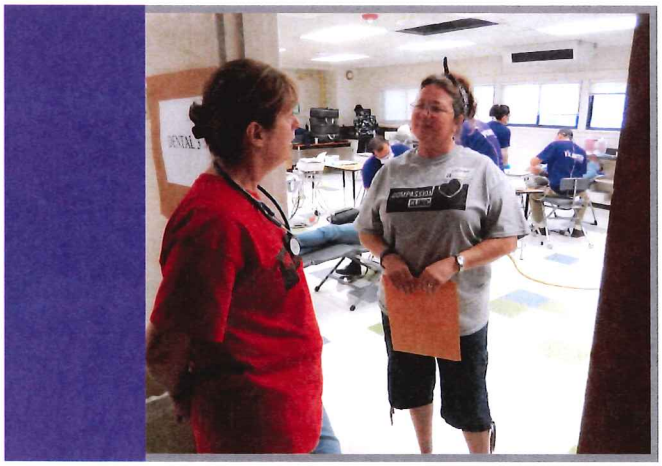
People across the political spectrum have hailed the use of Individual Development Accounts (IDAs). These are savings accounts that can be used for specific, legally-defined purposes, which, as of now, do not include healt care, but could.

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 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."[17] 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.[18]

Under Idaho law, an IDA can be used specifically



for college savings, to buy a home or start a business.[19] 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.[20]

In the Boise Valley, 33 people enrolled in the IDA, of which 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.[21]

Idaho law, at present, does not allow people to use IDA accounts for health-related purposes, though it could.[22] Additionally, such savings accounts could be augmented with matching dollars in order to dramatically boost the savings that could be used for healthcare 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 for matching funds 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.[23] Last year, about $300,000 was returned to the cooperative welfare fund for this purpose.[24] Idaho lawmakers could provide taxpayers with the option of utilizing the funds for healthcare costs, possibly matching the money put in by charities for IDA accounts.[25] Re-allocating general fund money from the catastrophic health program toward this program would also be a reasonable, temporary step.

An Individual Development Account is just one tool being used by the volunteer sector — charities and related non-profit organizations — to help people who are trying to elevate their economic stature. Other opportunities exist to 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.

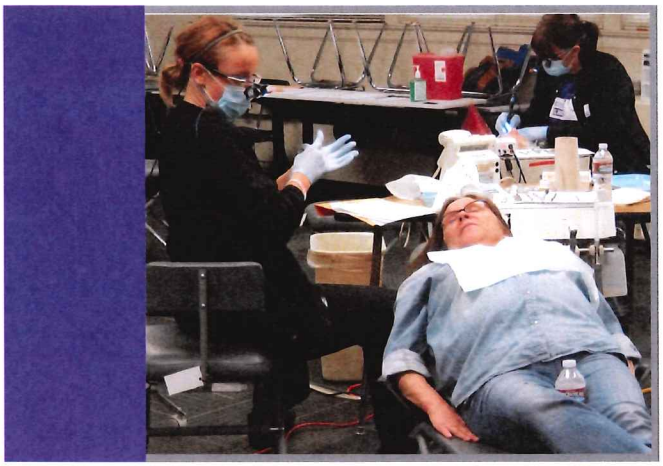
Groups already offering help

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 10 years. The non-profit organization has a budget of about $2 million and operates two programs, funded almost entirely by private donors.

PROJECT access NORTHWEST SINCE 2006

The first program connects low-income, uninsured patients with specialty doctors. These doctors volunteer to offer their services to two patients a month.[26] Other practitioners elect to serve 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.[27]

Project Access Northwest 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.[28]

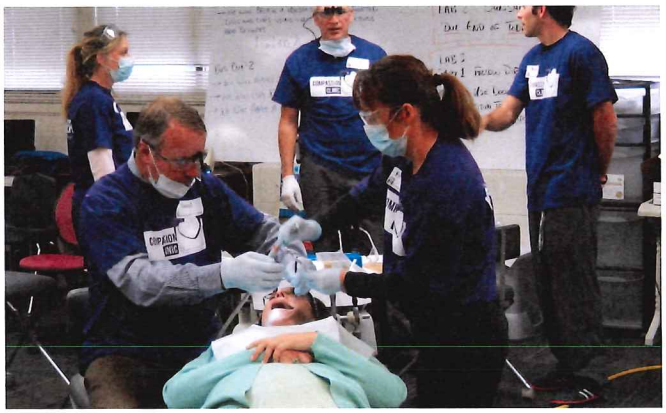
COMPASSION CONNECT
uniting to serve

Compassion Connect, of Portland, is another example of an organization doing good work for people of limited means who do not have access to affordable healthcare. Compassion Connect works with groups of churches to set up free health clinics both in the Pacific Northwest region and across the globe. Love Caldwell, a volunteer organization that works to help people and the community, held a Compassion Connect free clinic on Sept. 10, 2016, the third time it had done so. The clinic sees hundreds of patients, offering medical screenings and dental care.

Jim Porter, a pastor at Caldwell Free Methodist Church and a member of Love Caldwell, said the program is also an opportunity for community residents to show their support for their neighbors. As many as a third of Love Caldwell's clinic volunteers are medical professionals. "The remaining two-thirds are just people who recognize there are people who live among us who have profound needs and need a human touch," Porter said.[29] Many of these volunteers are teenagers, and Porter said he believes such youth participation could lead to a lifetime of community involvement and caring.

LOVE CALDWELL

Compassion Connect Executive Director Milan Homola said the organization is based on a belief that it is a moral imperative for neighbors to take care of one another, and that churches must work together for the betterment of the people in the community as part of church ministries.[30] In addition to providing standard healthcare services one might expect at a free clinic, the Compassion Connect clinics also help the poor by offering podiatry and haircuts, aimed at improving the quality of life for people who otherwise would not be able to afford such attention.



Homola said hospital systems participate in the clinics because they recognize the return on investment by providing services today rather than waiting for someone to show up at a hospital emergency room, which is the most expensive way to deliver care services.

Caldwell is also home to another successful volunteer-driven program that provides medical care to the needy. The Canyon County Community Clinic started after a Bible Study group decided it wanted to give back to the community. Members contemplated starting a coat drive or participating in a soup kitchen during Thanksgiving and Christmas. Instead, they decided to engage in the community in an ongoing, dramatic way by starting a clinic that utilizes the services of volunteer doctors and other practitioners. Originally, the clinic saw patients just one day a

We only ask that volunteers be able to serve in a manner that is consistent with the love of Jesus Christ as that is the foundation of which our services are freely given to our patients.

week. Today, the patient offers services three days a week and has a permanent headquarters in downtown Caldwell.

Though the clinic started as a faith-driven endeavor, it welcomes people from all walks of life, as noted on the organization's website:

> The Clinic endeavors to nurture the longstanding traditions of volunteerism and community service among health care professionals, and strives to foster a collaborative team-oriented approach to addressing the needs of the under served and uninsured.
>
> Volunteers are critical to the Canyon Clinic. We have volunteer opportunities for everyone, including medical and counseling professionals, students, and retired and working people. While we acknowledge that the dream of opening the clinic was ignited by our desire to share the love of Jesus Christ with others, and we are unabashed about our Christian faith, we do not require any volunteers or patients to adhere to the same faith we do. We only ask that volunteers be able to serve in a manner that is consistent with the love of Jesus Christ as that is the foundation of which our services are freely given to our patients.[31]

Immunity for doctors and continuing education

Idaho already has a law that provides liability immunity for doctors providing care to patients at free clinics. This liability immunity, by law, can only apply upon the written, voluntary consent of the patient. But that law does not include free care conducted elsewhere. A simple change to state statute would allow doctors to offer free care in their own clinics. This has practical advantages to physicians who are seeing other patients in addition to their charitable activities. Some states mirror Idaho in providing liability immunity only at free clinics, while other states, like Montana and South Carolina apply the immunity wherever the care is administered.

Florida and Georgia, meanwhile, are among states that use sovereign immunity. Under this kind of arrangement, the medical provider is considered a "state actor" for the purposes of their charitable services. In that case, the state would intervene on behalf of the doctor in the event of a malpractice claim.

Sovereign immunity may be considered less preferable an arrangement by some, given that it denotes that charity care can only occur under the watchful eye of government. Sovereign immunity also makes it so that a patient has to challenge the government, with its near-unlimited resources, in the pursuit of a legal claim. However, Florida officials consider the program successful, with only 10 lawsuits having been filed since 1992.

Florida's laws also allow medical practitioners the option of providing free or reduced-cost medical services in lieu of continuing education credits. By one estimate, a Florida-style sovereign immunity arrangement plus continuing education credits would provide Idahoans with more than 18,360 potential free medical visits, saving them $10.4 million.[32]

One more note of caution with regard to any of these suggested policy changes: a statute that is written expressly for the purpose of offering "free" care, could fall into the same trap as other programs in which there are no expectations on the part of the patient. It may be preferable to include low-cost or reduced-cost services, so that professionals that choose to charge a minor amount in order to encourage investment and participation on the part of the client can do so.

Conclusion

Americans have a rich history of caring for one another, particularly when it comes to healthcare needs. 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 healthcare professionals. 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.

Endnotes

1 Title 39, Chapter 77, Idaho Code.
2 Title 56, Chapter 11, Idaho Code.
3 Tocqueville, Alexis de, Harvey C. Mansfield, and Delba Winthrop. 2000. Democracy in America. Chicago: University of Chicago Press.
4 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.
5 David Green, Reinventing Civil Society: The Rediscovery of Welfare Without Politics, 1993.
6 David Beito, From Mutual Aid to the Welfare State, University of North Carolina Press, Chapel Hill, 2005.
7 Ibid.
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10 Beito, "Lodge Doctors and the Poor," May 1, 1994. https://fee.org/articles/lodge-doctors-and-the-poor/
11 Journal of the American Medical Association, Volume 63, 1914.
12 James L. Payne, "Why the War on Poverty Failed," Foundation for Economic Education, January 1999, https://fee.org/articles/why-the-war-on-poverty-failed/
13 Ibid.
14 James. L. Payne, "Overcoming Welfare: Expecting more from the poor—and from ourselves," Basic Books, 1998.
15 Ibid, page 82.
16 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.
17 Individual Development Accounts and Other Asset Tools, Annie E. Casey Foundation, August 2006.
18 Assets for Independence Report to Congress, Oct. 11, 2012.
19 Title 56, Chapter 11, Idaho Code.
20 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.
21 Ibid.
22 See proposed draft legislation from 2016.
23 Idaho Code 63-3024A.
24 Data from the state Tax Commission.
25 See attached draft.
26 IFF interview with Sallie Neillie, executive director of Pacific Access Northwest, Aug. 23, 2016.
27 Ibid.
28 Ibid.
29 Email to Idaho Freedom Foundation, Sept. 7, 2016.
30 Interview with Milan Homola, Sept. 10, 2016 in Caldwell, Idaho.
31 http://www.canyon-clinics.org/about, accessed Sept. 11, 2016.
32 Volunteer Care: Affordable health care without growing government, The Foundation for Government Accountability.