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Guest Voices

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Rebecca Phillips is wearing a black, narrow-brimmed hat, and has both a crucifix and reading glasses hanging from her neck. She leans hard on her cane as she limps down the aisle created by tall steel shelves holding jars of peanut butter and boxes of Cheerios. Phillips turns toward a handful of rooms tucked in the corner of this converted Indianapolis warehouse that now serves as a St. Vincent de Paul food pantry. The "Gennesaret Free Clinic" sign hangs at the entrance of a waiting room filled with furniture ranging from a single blonde-wood church pew to a red chair with the back broken off. Across from a shelf displaying brochures on Type 2 diabetes and hepatitis C, a typewritten list of the clinic hours is affixed to the wall with packing tape.

For more than 40 years, Phillips worked as a cook at nursing homes and restaurants. But when arthritis finally forced her off her feet, there was no pension or health insurance waiting for her. She gets a Social Security check, but it barely covers rent and food. She can't afford to pay the premiums and copays required by the Medicare prescription drug benefit.

Phillips' blood pressure medicine alone costs $150 a month at the pharmacy, and she has other prescriptions, too. One, a cream for a leg wound, cost $75. She only filled that prescription once. The other medicines she gets here. After she sees the doctor, the volunteer pharmacist hands her prescriptions to her in a small brown paper bag with the logos of the local Dairy Queen franchise that donated it. "Thank God for the clinic," she says.

Rebecca Phillips is not alone. Even after the expansion of healthcare coverage under the Affordable Care Act, 30 million Americans have no health insurance. Four of 10 working Americans have only a high-deductible plan, which still leaves them responsible for paying several thousand dollars of costs out of pocket before their insurance pays for any care. Even medicines that have been around for decades, such as insulin, are priced so high that one in four Americans with Type 1 diabetes are rationing their supplies, leading to multiple reported deaths of young persons with Type 1 diabetes who could not afford the medicine. Physician researchers estimate they are among tens of thousands of Americans each year who die because they cannot afford some form of care.

Multiple legislative plans have been put forth to address the crisis. The most ambitious is usually referred to as "Medicare for All," which would mimic the

Canadian system, replacing private health insurance with a federal government guarantee to pay all essential healthcare costs. Other proposals are less ambitious, seeking to expand the Affordable Care Act.

Yet the statistics and the policy bullet points are abstractions of the story of Rebecca Phillips, living in the only high-income nation that does not have a public healthcare system that provides universal care. And Tina Tanselle, a licensed nurse practitioner who drives a hour to Indianapolis from her home in Crawfordsville to volunteer at the Gennesaret clinic, says Phillips' story is far too common. "You see people here who know exactly what medicines they need, but they just can't afford them," Tanselle says. "With a condition like high blood pressure, this is frightening. If you don't have the medicines you need, things can go very wrong."

The risk of bad outcomes is on Phillips' mind, too. Before she came to the clinic today, she called her son and begged him to join her. This past week, he had been hospitalized for high blood pressure. It was not the first time. He too has a prescription, but can't afford to fill it. She cranes her neck to see if he is in the waiting room. "These drug prices are crazy," she says.

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In 1988, cardiologist Jim Trippi joined others from his Roman Catholic parish who were volunteering at an Indianapolis soup kitchen for the homeless. As he watched people walk through the line with obvious, untreated physical ailments, he felt restless. "I thought, 'Maybe I could do a little more here than just hand out donuts' ", he says.

The soup kitchen rebuffed Trippi's offer to start a free health clinic — too many liability concerns, he was told. But he heard that a nearby Episcopal church was already opening up its pews each night to 80-plus homeless people. The pastor there embraced Trippi's offer.

Trippi and a nurse showed up at the church with a steamer trunk full of sample medicines and tongue blades. Their first patient was a young homeless man that Trippi and a nurse had to examine in the church's nursery, which had plenty of toys but neither chairs nor tables. "He had to lay on the floor, and we had to get on our

hands and knees to examine him," Trippi says. "It was humbling for all of us."

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From there, Gennesaret's free clinic has grown to include seven clinics, two mobile medical units, and three health recovery homes for homeless men and women. Over 200 volunteer healthcare professionals supplement the work of a paid staff. Gennesaret is intentionally interfaith in its mission, and its volunteers and staff come from a range of traditions.

On the one hand, Trippi is gratified by all of this. "It has truly been a privilege every day and in every way I have served," he says. But he was never planning to still be doing this. "I was hoping we would be out of business by now." Gennesaret preceded the creation of the Medicare Part D prescription drug benefit in 2003 and the Affordable Care Act passage in 2010. But, to Trippi, Gennesaret's continued existence is a painful reminder of continued gaps. "Call it what you will: Medicare for All, healthcare for all, universal healthcare. We need to get to a place in this country where medical and dental needs are taken care of," he says.

At age 48, Michael Mays Jr. still has an athletic build. But there is an audible wheeze every time he exhales. Mays has lived with asthma since birth, so he knows every trick to managing the disease. He does breathing exercises, and he avoids extreme temperatures as much as he can.

But Mays has no workaround for the ever increasing cost of his asthma inhalers, which average out at $380 despite being available for a fraction as much in other countries. The resulting under-treatment of asthma is a common, and dangerous, cause of emergency room treatment.

Nor is there a breathing technique to fix the U.S. health insurance system's unique status among high-income countries in its reliance on employer-provided health insurance. For workers like Mays, this means he is offered insurance on the job, but it does not equate to healthcare. The monthly premium for his employer-offered insurance would be $240, with a large deductible still to meet before the policy would cover any costs at all. So Mays gets his inhalers at this clinic and makes them last by taking half the dose his doctor recommends.

Kim Murphy was hospitalized a few months ago, and diagnosed with severe asthma, chronic obstructive pulmonary disease and high blood pressure. She works as an office assistant, but her job categorizes her as an independent contractor instead of an employee, so she does not have health insurance.

To Murphy and the other patients filling the waiting room, clinic's services are needed and appreciated. But the physicians and nurses and pharmacists who volunteer here are quick to point out, it is no substitute for a comprehensive system. They have no place to send samples for lab testing. The pharmacists can only dispense medicines that happen to be stocked in the limited back-room supply. That does not include insulin. The physician on staff says persons with diabetes should be getting their doses determined and monitored by an endocrinologist.

Of course, no surgeries are conducted here, no chemotherapy, no in-patient care. For people like Kim Murphy, she can only get that kind of care on an emergency basis — and then await the bills that garnish paychecks and lead to bankruptcies.

At the hospital, a social worker helped enroll Murphy in the state's Medicaid program. But a clerk in the program later concluded that Murphy's adult daughter was living in her household, and the daughter's income put Murphy over the program's limit. The daughter does not actually live with her, but Murphy was unable to get anyone in the bureaucracy to listen to her explanation. She was cut off, a common occurrence in state Medicaid programs, especially those run by for-profit corporations.

So Murphy comes to the clinic here and cobbles together coupons that usually allow her to be able to afford her blood pressure medicine. But when she went to the pharmacy to get the inhaler her doctor prescribed for her asthma, she was told the cost would be more than $400. She walked out of the store empty-handed.

"Who can afford that?" she asks.

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