

The Book of Resolutions
of The United Methodist Church
2008

#3201. Health Care for All in the United States

Theological and Historical Statement

From our earliest days United Methodists have believed that providing health care to others is an important duty of Christians. John Wesley found ways to offer medical services at no cost to the poor in London. The first Methodist Social Creed (adopted in 1908) urged working conditions to safeguard the health of workers and community.

The provision of health care for all without regard to status or ability to pay is portrayed in the parable of the Good Samaritan (Luke 10:24-35) as the duty of every neighbor and thus of every person. In a conversation that began with the question of how one might obtain eternal life, Jesus asserted that one must love God and one's neighbor. In response to the next question as to who one's neighbor is, Jesus portrayed a Samaritan, an outsider, who coming upon a wounded traveler, provided him with health care. Jesus portrayed the duty to provide health care as (1) one that is owed regardless of the merit or ethnicity of the person in need; (2) one that is owed to the limit of one's economic capacity – the Samaritan told the innkeeper, "Take care of him; and when I come back, I will repay you whatever more you spend", and (3) a duty that one neglects at the peril of one's eternal life. In a democracy, our duty to our neighbor merges with the duties that the Hebrew scriptures assign to government: the prophet Ezekiel denounced the leaders of ancient Israel whose failure of responsible government included failure to provide healthcare: "you have not strengthened the weak, you have not healed the sick, you have not bound up the injured, you have not brought back the strayed, you have not sought the lost, but with force and harshness you have ruled them" (Ezekiel 34:4, NRSV). The United Methodist Church therefore affirms in our Social Principles (§162T) health care as a basic human right and affirms the duty of government to assure health care for all. In the United States today, however, fulfillment of this duty is thwarted by simultaneous crises of access, quality, and cost. The result of these crises is injustice to the most vulnerable, increased risk to health care consumers, and waste of scarce public and private resources.

Access Barriers are an Injustice to the Most Vulnerable

In today's United States, healthcare access is disproportionately afforded to the affluent, the employees of government and large corporations, the very poor, and many receiving adequate pensions plus Medicare. Forty-seven million Americans are uninsured, largely the self-employed, recently unemployed, middle income, and working poor. Lack of health care access affects minorities disparately, and the results of the devastating expense of a longterm or terminal illness, inadequate care in general, and the extraordinary cost of insurance all contribute to keeping many minorities in the poverty cycle, dependent on welfare and other forms of assistance, and imprisoned in struggling and dangerous communities. Disparities in access lead to disparities in treatment. The poor, the aging, women, children, people with disabilities, and persons of color are most at risk. The infant mortality rate in the United States is the worst among the "developed" countries. African-American women die from cervical cancer at three times the rate of Caucasian women. African-Americans have a significantly lower life-span than Caucasians and Hispanics have the least access to the health care system of any group. Native Americans, besides suffering greatly from alcoholism, have a substantially higher diabetes and tuberculosis rate than average U.S. rates. Recent immigrants who experience health problems find the health care system poorly equipped to meet their needs. We believe it is unconscionable and abhorrent that any human being should ever be denied access to adequate health care due to economic, racial, or class barriers.¹

Such barriers, however, are endemic to our current system of employer-sponsored health coverage. This system is eroding, covering a smaller percentage of Americans each year, and rendering American employers less competitive in a world market. When a covered employee has a health crisis affecting his or her ability to work, a whole family's coverage is jeopardized. Other difficulties with private insurance are that in a health care crisis, even those with insurance may have expenses that exceed the lifetime maximum under their policy. In some cases, the insurance policy may be cancelled just when it is needed most. Businesses are overwhelmed with the cost of health insurance.

Persons with chronic diseases face special challenges of inadequate resources both in availability of health care professionals and economic support. United Methodist Conferences increasingly find health care costs consuming dollars intended for ministry.²

Forcing Americans to rely on a safety-net program like Medicaid is unjust because if a health catastrophe should strike, those who have no coverage must deplete all assets in order to qualify for Medicaid, including selling of a home or surrendering a lifetime of savings. Even if this family is not among those who must declare bankruptcy in order to survive, these circumstances contribute to poverty, constant worry, and despair among many. While Medicaid provides some care to the poor, it does not encourage primary nor comprehensive care and disqualifies applicants with borderline incomes. Persons with episodic incomes are denied Medicaid during the period they have incomes, and therefore also receive episodic care. In addition, Medicaid systems remain under constant attack as one of the first places to cut the federal and state budgets, belying the claims of many civil leaders that health care is their priority.

Quality Issues Put All Patients at Risk

In the United States, the provision of health care has been transformed from a ministry to a commodity measured in patient encounters, tests performed, medications dispensed, and beds filled. In the process, quality of care suffers as the primary concern is often cost, not care. The physician-patient relationship is thereby compromised. Insurance companies in their efforts to reduce costs seek to control physicians' practice of medicine, thereby interfering with the physician-patient relationship. As a result, medical decisions are often made with primary consideration for the costs to the corporation, not for the optimum health of the patient. In the current climate physicians who prescribe treatments or tests not pre-approved by the insurance corporation face severe financial penalties or other disincentives to optimum patient care. Physician time is consumed with excessive paperwork, malpractice suits, and inadequate government programs.³

The American claim-based system produces enormous administrative burdens as well as denial of needed care. When claims are not denied by policy, they are often denied by the sheer burden of bureaucracy that must be overcome to obtain approvals. It has been estimated that today's physician spends about one-third of his or her time satisfying these insurance company regulations and seeking approvals for treatment, time the physician could be spending with patients. Competition for premium dollars and concern for high profits have taken priority over necessary care at actual cost. It is evident that private insurance companies are prone to deny claims while continuing to receive premiums, favoring higher profit over the "health and wholeness" of the weakened, the worried, and the sick. These same companies want to limit a patient's right to sue in civil court when the company breaches its own contract to provide benefits, regardless of the suffering or death a benefit denial may cause. In these types of cases a benefit denial is tantamount to medical malpractice.

Care Management has often been taken over by funding agencies rather than physicians. Managed care companies, HMOs, PPOs, and the like, interfere with the physician's ability to develop comprehensive treatment plans for his or her patients. They require that a decision be made by the corporation about treatment cost and efficacy. Medical decisions are in effect made by persons much less qualified than the patient's physician or the specialist a physician may recommend. In fact, persons with little or no medical training often make those decisions. Many insurance companies hire nurses to review the physicians' diagnoses and treatment plans. While it is unusual for nurses to oversee doctors, it is also evident that these nurses have had no contact with the patient under review.

Hospitals are required to provide uncompensated care. As a result, patients who are unable to pay for small primary care bills are able to incur large hospital bills when their untreated illness has become life-threatening. It has been estimated that the cost of uncompensated care included in each individual policy is \$341, and in each family policy is \$942.4 Hospitals can no longer stay financially sound under existing policies.

Hospital staffing, due to cost concerns, imposes burdens on patient care that compromises quality, issues reflected in unhappy staff and increased numbers of union complaints and strikes in recent years. Error rates due to overwork and other factors are a crisis; the Institute of Medicine estimates that 100,000 persons die in American hospitals each year as a result of medical errors.

Spiraling Costs Waste Scarce Resources

Per capita health care costs in the United States are more than twice the median level for the 30 industrialized nations in the Organization for Economic Cooperation and Development. The Centers for Medicare and Medicaid Services have estimated that by 2010, health care expenditures in the United States will reach \$2.6 trillion.⁵

While some of the escalating costs of health care can be attributed to advances in technology and the aging of the population, a very significant part is due to the nature of America's health insurance market, in which:

- Today's physician spends one third or more of his or her time satisfying insurance requirements and seeking approvals for service.
- Multiple insurance companies, programs, coverage, claims processes, create confusion, duplication, and unnecessary administrative costs. It has been estimated that the cost of administration of Medicare is 4 percent to 5 percent of its budget, while the typical private company's budget for administration and profit is about 25 percent. Health care provision is managed by a massive bureaucratic complex: more than 50 state and state-level Medicaid systems, the Department of Veterans Affairs, the Railroad Employees insurance program, Indian Health Service, federal and state employee systems, health care for retired military personnel, Medicare and countless programs of the various private insurance companies: HMOs, PPOs, Medicare Supplemental Plans, etc. These entities rarely communicate in similar terms: neither to patients, to physicians, or to hospitals, thereby complicating efforts of providers and patients to properly file and receive payments on legitimate claims.
- Premium increases are driven by requirements to show a profit rather than rises in actual costs of treatment. High premiums to support the high profit margins of private health insurance companies force people to choose between health insurance and sustenance, housing, or other needs of a family, making even basic health insurance too expensive for an average individual or family. High co-payments and uncovered costs lead to significant impoverishment.
- Costs are shifted to the consumer through increasing deductibles and co-payments for care.
- Ever smaller insurance pools are promoted, with increasing portions of risk borne by the patient. The culmination of this trend is promotion of personal policies, with high deductibles and extraordinarily high premiums of thousands of dollars per month, that an average family, much less the working poor, simply cannot afford.
- Annual or lifetime limits are often imposed on policies, whether individual, group, or institutional, as a means of limiting the risk of private insurance companies. These harsh policies simply pass the risk back to individuals at the very time they can least cope with it, leaving the lingering worry that with a catastrophic illness or injury such limits may be reached, abruptly stopping all insurance benefits and leaving the policy beneficiary completely uninsured.
- More than half of all personal bankruptcies are now the result of illness. Even individuals with ostensibly good insurance, let alone those who are uninsured, find themselves in situations where they must sell and/or spend all assets, including homes, financial holdings, lifetime savings accounts, etc., in order to qualify for Medicaid and restore any medical coverage at all.

Increased costs of health care inevitably impact state and federal resources available for Medicaid, often leading to reduction in the number of providers willing to participate, and ultimately to decreased access to health care for the poor and the physically or mentally challenged.

More and more Annual Conferences and even congregations are feeling the burden of providing health care to their clergy and their lay staff. Small churches, even multiple point parishes, have difficulty paying for increasing health premiums for clergy. Funds going to this purpose are in effect diverted from other important ministries.

The Vision of Health Care for All

The United Methodist Church is committed to health care for all in the United States and therefore advocates for a comprehensive health care delivery system that includes access for all, quality care, and effective management of costs.

1. Access for All. In a just society, all people are entitled to basic maintenance and health-care services. We reject as contrary to our understanding of the gospel, the notion of differing standards of health care for various segments of the population. The American Health Care system must serve and be sensitive to the diversity of all people in the United States and its territories. Regional planning processes should coordinate the services rendered by all health-care institutions, including those funded by governments, to create a more effective system of health services in every area. Priorities should be established for the provision of health services, such as preventive care, mental-health services, home care, and health education. Corrective measures should be taken where there is maldistribution or unavailability of hospital beds, intermediate care and nursing home care, home-delivered care, neighborhood health centers, community mental-health centers, and emergency care networks.
2. Quality Care. Health care should be comprehensive, including preventive, therapeutic, and rehabilitative services. The American health care system should provide comprehensive and portable benefits to everyone; including preventive services, health promotion, primary and acute care, mental-health care, and extended care. It should promote effective and safe innovation and research for women and men in medical techniques, the delivery of health services, and health practices. It should assess the health impacts of environmental and occupational safety, environmental pollution, sanitation, physical fitness, and standard-of-living issues such as housing and nutrition. Professional health-care personnel should be recruited and appropriately educated to meet the healthcare needs of all persons. Especially urgent is the need for physicians trained in geriatric medicine. Special priorities should be established to secure among the professional group at least proportional representation of women and minorities who are now seriously underrepresented. We encourage development of community support systems that permit alternatives to institutional care for such groups as the aging, the terminally ill and mentally ill, and other persons with special needs. We encourage medical education for laypersons that will enable them to effectively evaluate medical care they need and are receiving. Religious and other appropriate forms of counseling should be available to all patients and families when they are called upon to make difficult medical choices, so that responsible decisions, within the context of the Christian faith, may be made concerning organ transplants, use of extreme measures to prolong life, abortion, sterilization, genetic counseling, institutionalization, and death with dignity. We support the medical community in its effort to uphold ethical standards and to promote quality assurance.
3. Effective Administration of Care and Management and Financing of Costs. The American health care system must incorporate an equitable and efficient financing system drawn from the broadest possible resource base. It must reduce the current rapid cost inflation through cost-containment measures. It must provide services based on equity, efficiency, and quality, with payments to providers that are equitable, cost-efficient, and easy to administer and understand. The system must be sensitive to the needs of persons working in the various components of the health care system and gives special attention to providing not only for affirmative action in the recruitment, training, and employment of workers, but also for just compensation for all workers at all levels and for retraining and placement of those displaced by changes in the health care system.

Advocacy Steps

Globally, the church has a continuing duty to provide, in many parts of the world, the ministry of health care that government is unable to provide. In the United States, however, government has the capability to provide health care for all; doing so will extend health care to many who presently have no access, and doing so without the wastefulness of the current system will represent far better stewardship of resources than at present. The United Methodist Church supports a three-tiered approach to health care advocacy:

1. Single Payer. We call for swift passage of legislation which will entitle all persons within the borders of the United States to the provision of health care services, the cost of such services to be equally shared by American taxpayers, and the government to distribute the funds to providers in a coordinated and comprehensive manner. This concept, known as "single-payer," would extend health care to all persons in the United States. Choice of private doctor and other health care providers would be maintained. Public funds would make payment, and these funds would be generated by individual premiums and payroll tax. Studies have shown that this method can be achieved with no increase over what is already being spent on

health care from all sources. It therefore not only accomplishes the objective, but it best exercises our stewardship of public resources.⁶

2. Incremental Steps toward Single Payer. We recognize that much of the cost savings of “single payer” flow from the virtually total elimination of the health insurance industry. We cannot wait to overcome the current barriers to a single payer plan, and therefore support all initiatives that move segments of our population closer to a single payer system. Particular incremental steps that we support include the State Child Health Improvement Program (SCHIP), which should be extended to achieve health care for all children. We do not support legislation that requires individuals to choose to purchase health insurance from multiple insurance companies, because such bills radically waste resources through duplication of service, burdensome administration, marketing costs, and profits. They inherently promote “adverse selection” in which the sickest people sign up for the plans with the best benefits. Such plans drive up the costs, while healthy young workers sign up for plans with the poorest benefits, therefore removing them from the risk pool.
3. Recognizing that the nation is deeply divided nationally on the philosophical bases for addressing America’s health care delivery problems, we support state-level initiatives in which individual states, at their own initiative become laboratories for trying out varying approaches to providing health care for all. We support in particular efforts at the federal level to support state-based efforts through necessary waivers of federal regulations.

Bringing America’s health care crisis under control will call upon the efforts of every sector of society and demand both personal and social responsibility. We therefore call upon all United Methodist persons and entities to do their part:

- Individuals. We call upon United Methodist individuals and families to pursue a healthy lifestyle, preventing many health problems before they start and strengthening physical capacity to combat problems which do arise.
- Health Care Institutions. We call upon United Methodist affiliated health care institutions to adopt, reaffirm, and strengthen policies supporting care delivery which is Christ-like, compassionate and wholistic rather than fee driven and compartmentalized. We call upon such institutions as a requirement of their affiliation, to develop United Methodist standards of care which distinguish them from profit-driven, secular institutions.
- Seminaries. We call upon United Methodist seminaries to develop curricula linking sound biblical theology with clergy self-care and advocacy for universal health care.
- General Agencies. We call upon all Agencies, Commissions, and Annual Conferences of The United Methodist Church in the United States to adopt principles and support policies which are consistent with this resolution.

We charge the General Board of Church and Society with primary responsibility for advocating health care for all in the United States Congress and for communicating this policy to United Methodists in the USA.

ADOPTED 2008

See Social Principles, ¶162T.

¹ United States Bureau of the Census, Centers for Disease Control and Prevention, and U. S. Department of Health and Human Services – Office of Minority Health.

² United Methodist Reporter, 1990, 2004

³ The Directives of the American Medical Association House of Delegates address these issues at each meeting.

⁴ Impact of Health Care for the Uninsured on Health Insurance Premiums, for Private Employer Coverage, 2005, National Average. Families USA, “Paying a Premium: The Added Cost of Care for the Uninsured, 2005

⁵ “Building a Better Health Care System: Specifications for Reform.” National Coalition on Health Care. 2004, p. 8

⁶ Lewin Group, “Analysis of the Costs and Impact of Universal Health Care Models for the State of Maryland: The Single-Payer and Multi-Payer models” Report to Maryland Citizens Health Initiative Educational Fund. May 2, 2000.