Mennonite Church USA

Atlanta 2003 Delegate Assembly

Health Care Access Resolutions for Delegates

Prepared by the Anabaptist Center for Health Care Ethics

April 17, 2003

The Anabaptist Center for Health Care Ethics has agreed on behalf of Mennonite Church USA Executive Board, to facilitate the activities necessary to implement the following resolutions. For this work, The Anabaptist Center for Health Care Ethics will represent the collaborative efforts of the following organizations: Mennonite Health Services, Mennonite Mutual Aid, Mennonite Central Committee, Mennonite Chaplains Association, Mennonite Medical Association, and Mennonite Nurses Association.

Resolved:

1. That Mennonite Church USA develop a new Resolution on Health Care in the United States, taking into account the current problems of access to health care along with the resolutions on record from the former General Conference Mennonite Church (1992) and the Mennonite Church (1993).

Special instructions: The new resolution will be disseminated in draft format to Assembly Delegates of record by no later than July 2004, with the understanding that their feedback will be received and integrated into a final statement for delegate action at the 2005 Delegate Assembly.

2. That Mennonite Church USA authorize the Access Initiative, a project to demonstrate our commitment, as a community of faith, to universal access to health care by developing models that focus on helping congregations deal with problems of access to health care. These models will incorporate the following principles:

- Access to health care for all persons (The starting point in this project will be Anabaptist congregations and the lives they touch.)
- Emphasis on health promotion and prevention of illness
- An emphasis on healing and caring rather than focusing only on curing
- Recognition of our mortality and the limits required by stewardship of scarce resources

Special instructions: The project team will explore the unique resources and talents of Mennonite health care professionals and provider organizations. They will collect, organize, and disseminate stories from providers and church members, work with key stakeholders, and begin engaging congregations interested in developing an access model in their communities. A progress report will be provided for delegates at the 2005 assembly.

The pages that follow provide additional background, rationale, and vision for this work.

A Prospectus on Health Care Access

for

Atlanta 3003 Assembly Delegates

April 17, 2003

1. **Why is access-to-care a high priority at this time? The US health care system today is a system nearing chaos.**

The problems are numerous.

- ***Uninsured***. Over 40 million persons, or nearly 20% of all persons under age 65 in our country do not have health insurance. Disproportionate numbers of these persons are children and heads of single parent households. A recent study showed there were 75 million people without health insurance at some point during the past two years. Many of these persons find their work in jobs paying a subsistence wage.
- ***Affordability***. Health insurance costs are exploding! During the past year employers experienced average cost increases of 15% in their health insurance plans. Employers, in an effort to manage this financial strain are passing along more of their costs to employees. Persons who have insurance are finding that the cost of insurance is increasing by substantial amounts even as they are subject to ever-greater restrictions in the services offered under their present coverage.
- ***Insurance underwriting***. In order to provide competitive health insurance plans, insurers are forced to screen new entrants, selecting wherever possible the populations least likely to require high cost medical care and excluding known illnesses from coverage for extended periods of time.
- ***Consumer behavior***. As consumers of medical care we must also own our complicity in the problem. At its core, the crisis in health care involves our misguided values and beliefs: our obsession with physical health, our unrealistic expectations of the medical profession, our fear of death, our faith in unlimited scientific progress, and our individualism. Our appetite for expensive care and our assumption that any available technology is ours for the asking makes the prospect of controlling costs an unreachable dream. In the interest of finding the "best price" or the lowest cost insurance we make choices to support plans that discriminate against the chronically ill who are most in need of care.
- ***Challenges for institutions***. Mennonite health care organizations, senior care, behavioral health, and disability service providers are trying to operate in this context. They deal day-to-day with the growing challenges of the uninsured, the under-insured, and declining reimbursement from state and federal sources.
- ***Where is community?*** We place unreasonable expectations on MMA by expecting them to provide health insurance for high-risk groups and then select our coverage elsewhere in order to reduce our insurance expenses.
- ***Stewardship of health***. We must accept the role that our life styles contribute to the consumption of medical care. It is safe in our faith community to speak of the excess costs related to the consumption of alcohol or the use of tobacco and other drugs. It is also time that we consider the price we are extracting from the health care system by our sedentary life style and our dietary habits. We need to adopt the language of stewardship when we speak of our health or physical well-being. The God who cares about how we steward our time, talents and money is also concerned about how we care for our bodies. How well we care for our bodies has a direct impact on our cost to the health care system.

2. What have Anabaptists already said about access to health care?

In 1992 – 1993 the predecessor denominations to Mennonite Church USA each adopted a Resolution on Health Care. (See Exhibits 1 and 2.) The resolutions identified four foundational principles that should undergird a just health care system. We said, “the church is called to respond to this crisis out of its biblical concern for both healing and social justice. These concerns are evident in the message of Jesus: "The Spirit of the Lord is on me, because he has anointed me to preach the good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favor" (Luke 4:18-19).” In response we called for a system that:

- Provides access to health care for everybody everywhere in the U.S.;
- Places emphasis on health promotion and prevention of illness;
- Emphasizes the role of healing and caring rather than focusing only on curing;
- Recognizes our mortality and the limits required by stewardship of scarce resources.

We spoke of our concern because of our “belief in the sanctity and dignity of persons created in God's image. This commitment to justice calls us to free people from social structures which deny them that dignity. Our concern for stewardship calls us to use our limited resources wisely and in the promotion of justice.”

We continue to believe all of these were and are laudable goals and believe the intervening years require that those resolutions be updated and strengthened. We further believe that the conditions those resolutions addressed have worsened since their approval. We confess that we have not consistently sought the image of *justice* and *responsibility* these aspirations call us to.

3. What do we, as Anabaptists, have to offer in responding to the present access dilemma?

As Anabaptists, we are called to help shape the vision for a better and more just health-care system. We should be demonstrating by our actions that we are working to implement this vision. We commend the following historical events as a challenge and an encouragement to energize us to carry forward this agenda.

Civilian Public Service. Mennonite and Brethren Conscientious Objectors in the Second World War and the Korean conflict were instrumental in revolutionizing the treatment of the mentally ill and those in prison. We believe this story demonstrating the power of a small group of dedicated persons should give us hope that our voice can carry weight beyond our numbers to foster yet another social good for our society. As we spoke out for the voiceless and the weak fifty years ago so should we demonstrate our care for the voiceless and marginalized today. That history has demonstrated for us the power of a small group speaking truth into a larger system. We have lived out our beliefs in history. By doing so now we will create a new history for our country and our people.

Health Care Workers and Organizations. By the middle of the 19th century Mennonites were already developing institutions of care – for widows, children, and the homeless. Today we have a large number of Mennonite-affiliated ministries spread across the country caring for the mentally ill, the frail, elderly, and those that are developmentally challenged. These institutions are under stress today because of the pressures on the health care system. Each such institution has the potential to become part of the solution to the problem of access to care as they, being part of the faith community, seek to be faithful to their charge to minister to all people.

128 In addition, we have a higher than average proportion of Mennonites in the caring
129 professions. These individuals care deeply about their work and believe that their faith
130 shapes their practice. They too struggle to know what it means to be faithful in the context
131 of a "broken" system. They have important perspectives and resources to share within the
132 community of faith as we create new ways of caring.

133 ***Anabaptist Beliefs.*** As Anabaptists we understand that following Jesus means a daily
134 responsibility to practice what we believe. We believe in justice and self-responsibility
135 because we are accountable for our actions.

136 We are a congregational and community people. We value relationships within our families,
137 our congregations, and the wider church. We tell our stories of support and care within the
138 congregation. We tell them for all to hear and by doing so we challenge all to be supportive
139 of each other and for the church by their actions. We respect and value the gifts each person
140 brings within our community.

141 We believe that being a good steward of our health is not just seeking treatment for our acute
142 and chronic illnesses, but attending to our spiritual, mental, emotional, and physical well-
143 being. We believe in working together to provide mutual support for each other, and to
144 support community needs beyond ourselves.

145 We believe in showing compassion to those in need in our communities. We will commit
146 ourselves as a body to identifying with those who are cast aside by the present system. We
147 will begin by caring for those in our midst who lack basic medical insurance. We will call
148 our people to sacrifice their own advantage for the purpose of enabling all who are
149 connected with the Anabaptist community to access health care.

150 **4. Organizing a response – a proposal for consideration.**

151 Mennonite Church USA will authorize and initiate a project to demonstrate our commitment,
152 as a community of faith, to universal access to health care by developing:

153 a. A new Resolution on Health Care in the United States, and

154 b. Models that focus on helping congregations deal with the problems of access to
155 health care based on the guiding principles noted above.

156 We will call on our brothers and sisters in the Anabaptist community to join in this effort –
157 the "Access Initiative."

158 The Anabaptist Center for Health Care Ethics will be asked to facilitate the implementation
159 of this initiative. Sponsors joining in this effort will include Mennonite Health Services,
160 Mennonite Mutual Aid, Mennonite Central Committee, Mennonite Chaplains Association,
161 Mennonite Medical Association, and Mennonite Nurses Association. They will assemble a
162 panel of church and business leaders who will bring visibility to this effort as well as offer
163 guidance and energy to the initiative. They will make resources available for congregational
164 and conference leaders, including information and workshops on the subject. Together we
165 will gather with Anabaptists in all fields related to health care delivery and usage to listen to
166 their stories, concerns, and suggestions. We will encourage exploration of alternative
167 systems of medical care delivery. We will seek to be an advocate for all who are
168 marginalized, and to stimulate congregational dialogue with this issue. We will ask "*What*
169 *does being a person of faith living in community have to do with access to health care?*"

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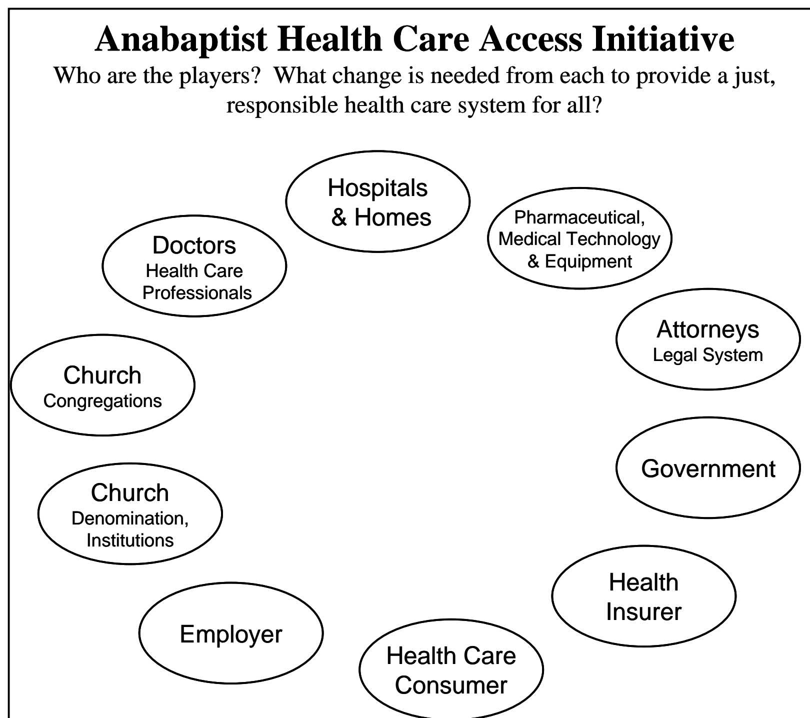
Through the Access Initiative we will solicit the creativity of many persons who will be able to offer counsel about the values that should be in operation for a truly just health care delivery system. Groups identified include: physicians and other health care professionals, health care administrators, pharmacists, government, insurers, employers, attorneys, denominational leaders, and consumers. We will ask these questions:



- *What will it look like if the household of faith got serious about providing universal access to health care?*
- *What will you be willing to contribute in order to provide universal access to health care for all Anabaptists and the lives they touch in a given geographic community?*

While the ultimate goal from our perspective of justice is to include all persons, everywhere in the United States, the starting point for this project will focus on interested Anabaptist congregations and their needs.

We will seek to publicize the failure of justice and stewardship in health care delivery in our country. We will endeavor to build this consensus first in the Anabaptist community and will find opportunities to add our influence to other groups who also seek justice and responsibility in health care delivery. In so doing, we will become a part of the grassroots initiative that will be required to bring about the changes needed in our health care system.

5. Here is a vision for a new order

We will insist that our committed church leaders not have their health care insurance jeopardized because of their health care history or by the financial hardship that health care insurance has become.

Each congregation will be engaged in health care advocacy and counsel for their members who desire it. Every person will have a home for health care.

Our potlucks will no longer look like an invitation to a heart attack.

We will find and publicize ways to promote the stewardship of health through various means (exercise, diet, stress reduction, etc.) leading to a greater sense of well-being. We will promote wellness of the whole person, and create healing environments which integrate treatment for the body, mind, emotions, spirit, and soul.

213 We will tell stories about collaboration within the congregation for the care of those who are
214 ill or dying. We will hold these up as examples of the best values of community.

215 We will tell stories of heroes of the faith who renounced health care options with the
216 potential of prolonging life for the short term in order to find time and space to build and
217 strengthen relationships during the dying process.

218 We will hear of congregations where members have covenanted to be accountable to each
219 other in choosing degrees of health care, trying to balance the "right" for services with the
220 "expense" to the community in choices related to: infertility treatments, obesity options,
221 cosmetic surgeries, choice of prescriptions, etc.

222 We will hear of committees and reference groups within congregations that are available to
223 help other members navigate the many decisions that must be dealt with in the closing weeks
224 of life.

225 We will hear testimonies of those who have been challenged to live a life of meaning
226 because of the witness of one who died in Christ.