



Advisory Committee
On Social Witness Policy



Presbyterian Church (U.S.A.) • 100 Witherspoon Street • Louisville, KY 40202-1396
PDS #68-600-02-004

**Resolution on
Advocacy on
Behalf of the
Uninsured**

Advisory Committee
On Social Witness Policy

PRESBYTERIAN CHURCH
(USA)

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Published 2002 by
The Advisory Committee on Social Witness Policy
www.pcusa.org/acswp

and

Health Ministries USA, National Ministries Division
www.pcusa.org/health/usa

of the General Assembly Council, Presbyterian Church (U.S.A.)

Printed in the United States of America

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Louisville, KY 40202-1396

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Forward

The Advisory Committee on Social Witness Policy (ACSWP) was asked by the 211th General Assembly (1999) to develop a resolution that addresses the need for advocacy on behalf of uninsured persons, especially those with low income or fixed income. In adopting the *Resolution on Advocacy on Behalf of the Uninsured*, the 214th General Assembly (2002) recognized that the church must provide not merely a moral whisper of conscience, but a chorus of voices raised in a call for immediate action.

Historic inadequacies in our health care system and the distribution of services through that system leave millions without the means to obtain even the most basic health care for themselves and their families. While continuing escalation of health care costs affects all of us, the effect on the most vulnerable is devastating. Individuals on fixed incomes become at greater risk. People (and their families) who have lost jobs and benefits due to the economic downturn are at risk. Individuals without private coverage or who do not qualify for government subsidized insurance are at greater risk than before because the number of health care providers willing to give treatment to medically indigent people is decreasing at an alarming rate. Rising co-payments and



deductibles, combined with stricter pre-authorizations and reimbursement caps, are affecting health care access for middle-income persons.

The resolution that follows offers a biblical and theological rationale in light of the current situation for church involvement advocating on behalf of uninsured persons. It also provides the framework for a congregational plan to advocate for health care access for all, as well as a copy of legislation currently before Congress and calling for basic access to health care for all. Several trends affecting the uninsured are then explored followed by an examination of the challenges ahead as Presbyterians seek to be responsible in both their public and private lives in the quest of furthering God's intention of health (shalom) for the earth and its people. The final section presents the recommendations approved by the 214th General Assembly as it met June 15-22, 2002, in Columbus, Ohio. In addition, Appendix I, "The

Challenge to Presbyterians from the 214th General Assembly: Adequate Health Care for Everyone” offers concrete ways for individuals and their congregations to respond in advocacy for the uninsured. It provides the framework for a congregational plan to advocate for health care access for all. Appendix II, “Health Care Access Resolution” (House Concurrent Resolution 99), provides a copy of legislation currently before Congress and calling for basic access to health care for all.

A small resolution team, appointed by the ACSWP and chaired by Margaret P. Elliott, met together as a group for study and the development of the resolution for the committee. Along with its chair, the group included the following: Peggy S. Barnett, Alfred B. Johnson, Robert Van Kemper, Sue Donovan Mooney, and William H. Thomas. Doug Grace served as staff from the Presbyterian Washington Office and Belinda M. Curry served as staff from the ACSWP.

In exercise of its responsibility to witness to the Lordship of Jesus Christ in every dimension of life, the 214th General Assembly (2002) of the Presbyterian Church (U.S.A.) has approved this resolution. It is present for the guidance and edification of the whole Christian church and the society to which it ministers. It will determine procedures and program for the programmatic divisions and

Forward



staff of the General Assembly. It is recommended for consideration and study by other governing bodies (sessions, presbyteries, and synods). It is commended to the free Christian conscience of all congregations and the members of the Presbyterian Church (U.S.A.) for prayerful study, dialogue, and action.

At the time of this printing, House Concurrent Resolution 99 is before Congress (See Appendix II). With 96 Congressional co-signers, the Resolution has not yet been brought to a vote. The call to Presbyterians from the 214th General Assembly to provide health care for everyone is our challenge.

Peter A. Sulyok
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Rationale

This resolution with recommendations is in response to the following referral: *1999 Referral: 25.037. Response to Recommendation Directing ACSWP to Develop Resolution Addressing Need for Advocacy on Behalf of Uninsured Persons, Especially with Low Incomes, with Necessary Funding, for Presentation to the 213th General Assembly (2001)—From the Advisory Committee on Social Witness Policy (Minutes, 1999, Part I, pp. 41, 308).*

Introduction

Of all forms of inequality, injustice in health care is the most shocking and inhumane

—The Reverend Dr. Martin Luther King Jr.

Almost a half-century ago, President Eisenhower referred to the “Military-Industrial Complex” as a powerful force to be reckoned with in the future of American society. The United States’ interests in global geopolitics have dominated global affairs since the end of World War II. Since then, our nation has been involved in conflicts in Southeast Asia, in the Middle East, in Latin America, and in Africa. Not so long ago, we sent military forces into the former Yugoslavia; now, in the wake of the events of September 11, 2001, we have become engaged in fighting against terrorists in Afghanistan. The pursuit of war abroad and

wealth at home have been higher priorities than global welfare and health.

Today, many of us have learned firsthand that the “Medical-Insurance Complex” has emerged as an even more powerful force in American life. Everyone knows someone who has complained bitterly, “I would quit this job tomorrow—but I can’t afford to. My child’s pre-existing medical condition would not be covered if I took the better-paying job that I have been offered in another company.” Despite the provisions of HIPAA (the Health Insurance Portability and Accountability Act of 1996), millions of Americans feel that they are “indentured” workers, trapped in their employer-based health insurance plans.

In the United States today, the ability to have health depends more than ever on having health insurance. Among the some 285 million people living in our country, more than 40 million have no health insurance and countless millions more are underinsured.² Only the United States among the industrialized nations of the world fails to offer its citizens some form of universal health care. Instead, Americans depend on a voluntary system of health-care policies paid (or co-paid) by employers, by one or more government agencies, or through the purchase of private insurance. At one time or another in our lives, almost every American is

at risk of facing a health crisis not covered adequately or not covered at all. Sometimes, the only solution to a medical crisis is to find a way to strip one's assets, declare bankruptcy, and become indigent so that government will provide the safety net that one's employer-based insurance plan failed to offer.

The numbers involved in the ranks of the insured are related to economic prosperity. Employer-based coverage increased from 1995 to 1999 as individuals moved to

better jobs during the unprecedented economic boom.

Conversely, during the earlier economic downturn in 1989–1990, two million

Americans lost their health coverage. The recent economic decline in 2001 suggests that additional millions of Americans again are at risk of becoming uninsured. When U.S. firms cut costs by moving jobs to other less-developed countries, they not only create more unemployment at home, they also eliminate substantial health-care costs from their corporate balance sheets. And when U.S. employers hire undocumented immigrant workers, they sometimes try to avoid paying

benefits, including medical insurance and even mandated Federal Insurance Contributions Act (FICA) taxes.

America spends about \$1 trillion each year on health-related matters, representing about 14 percent of its Gross Domestic Product. This is 40 percent more than any other industrialized country in the world. Yet our health indicators (e.g., life expectancy, infant mortality, heart disease, cancers) often trail far behind those of other countries.

Medical care in America may be better than ever. New drugs, new treatments, and new diagnostic tools have improved treatment of a wide range of

physical and mental conditions. The higher costs associated with these new medical technologies have elevated the problem of uninsurance into a national crisis. As a result, the National Academy of Science/Institute of Medicine's "Committee on the Consequences of Uninsurance" recently commissioned a series of six reports on the causes and consequences of lacking health insurance. The first report, published under the title *Coverage Matters: Insurance and*

Among the some 285 million people living in our country, more than 40 million have no health insurance and countless millions more are underinsured.

Health Care (Washington, DC: National Academy Press, 2001), examines why health insurance matters, considers the dynamics of health insurance coverage, and describes who goes without health insurance in our society.

Employer-based health insurance covers only about 66 percent of Americans under age 65, either through their jobs or through those of their parents or a spouse. Individually purchased policies and governmental insurance programs provide coverage to another 17 percent of the under-65 population. This leaves about 17 percent of the under-65 population without insurance through the year. For persons over 65, even Medicare does not cover all medical expenses. As these expenses increase, some persons living on fixed incomes find

that they cannot afford needed medical care even with Medicare coverage. Also, because some senior citizens often fail to understand completely the benefits available through Medicare, they may not take full advantage of the coverage paid for by their own and others' taxes (FICA).

Uninsurance falls disproportionately upon the poor, especially those working for minimum wages in small businesses that often do not offer health-care plans to their workers. Two-thirds of all uninsured persons are members of families who earn less than 200 percent of the Federal Poverty Level (FPL). The following table shows the general guidelines used by the Department of Health and Human Services to determine if a household falls below the FPL:

2001 Federal Poverty Guidelines				
Household size	Annual Income			
	48 Contiguous States and DC	Alaska	Hawaii	
1	\$ 8,590	\$10,730	\$ 9,890	
2	\$11,610	\$14,510	\$13,360	
3	\$14,630	\$18,290	\$16,830	
4	\$17,650	\$22,070	\$20,300	
5	\$20,670	\$25,850	\$23,770	
6	\$23,690	\$29,630	\$27,240	
7	\$26,710	\$33,410	\$30,710	
8	\$29,730	\$37,190	\$34,180	
for each additional person, add				
	\$ 3,020	\$ 3,780	\$ 3,470	

SOURCE: <http://aspe.os.dhhs.gov/poverty/poverty.htm>

These working poor are precisely the members of American society least able to afford to buy private health insurance at the same time that they are ineligible for most governmental insurance programs.

The findings in *Coverage Matters: Insurance and Health Care* provide a general profile of the uninsured:



■ **Work Status:** Eight out of ten uninsured people are members of families with at least one wage earner, and six out of every ten uninsured people are wage earners themselves.

■ **Income and Poverty:** Two-thirds of all uninsured persons are members of lower-income families (earning less than 200 percent of FPL). One-third of all members of lower-income families are uninsured.

Educational Attainment: More than one-quarter of all uninsured adults have not earned a high school diploma. Almost four of every ten adults who have not

graduated from high school are uninsured.

■ **Job Characteristics:** There are greater numbers of uninsured blue-collar workers than uninsured white-collar workers. Members of families with a

primary wage earner who is blue collar are more likely to be uninsured than are members of families with a white-collar worker.

■ **Employer Characteristics:** Wage earners in smaller-sized

firms, in lower-waged firms, in non-unionized firms, and in non-manufacturing employment

America spends about \$1 trillion each year on health related matters — yet over 40 million are without health insurance

sectors are more likely to go without coverage.

- **Age:** Three-quarters of the uninsured are adults (ages 18–64 years), while one-quarter of the uninsured are children. Compared with other age groups, young adults are the most likely to go without coverage.
- **Marital Status:** There are more unmarried than married adults among the ranks of the uninsured. Unmarried persons are much more likely than are those who are married to be uninsured.
- **Family Composition:** More than half of all uninsured persons are members of families that include

children. Individuals in families without children are more likely to go without coverage than those in families that include children.

- **Race and Ethnicity:** African Americans are twice as likely, and Hispanics three times as likely, as whites to be uninsured. More than one-third of all Hispanics under age 65 are uninsured. Almost one-third of all American Indians and Alaska Natives are uninsured, a rate almost as high as that for Hispanics.
- **Gender:** More men than women are uninsured, percentage-wise men are more likely than women to be uninsured.



Biblical and Theological Reflection

“There is no one to uphold your cause, no medicine for your wound, no healing for you” (Jer. 30:13, NRSV).

God’s intention of health (shalom), for the earth and its people, and Jesus’ promise of abundant life (health, healing, and restoration to wholeness in body, mind, and spirit) are central dimensions of the faith we profess and the vocation to which we are called as Christians. It leads the list in the order of service through which we participate in God’s activity through the church’s life for others by

- (a) healing and reconciling and binding up wounds,
- (b) ministering to the . . . poor and sick, the lonely, and the powerless,
- (c) engaging in the struggle to free people from sin, fear, oppression, hunger, and injustice,
- (d) giving of itself and its substance to . . . those who suffer,

- (e) sharing with Christ in the establishing of his just, peaceable, and loving rule in the world (*Book of Order*, G-3.0300c(3)(a)–(e)).

The health of a society is measured in an important way by the quality of its concern and care for the health of its people. How provisions are made for children in

the dawn of life, the elderly in the twilight of life, and the sick, needy, and those with handicapping conditions in the shadow of life are clear indices of the moral character and

At the minimum, credible commitment to health includes convenient access to quality, affordable, preventive and curative health services

commitment of a nation. At the minimum, credible commitment to health includes a safe environment; adequate food, shelter, clothing, and employment or income; and convenient access to quality, affordable, preventive and curative health services (*Life Abundant: Values, Choices and Health Care: The Responsibility and Role of the Presbyterian Church (U.S.A.)*, 200th General Assembly (1998)).

A consistent and persistent part of God’s revelation is the Creator’s concern for the wholeness and well being of human beings and our communities. The general vision of God’s shalom is revealed to us through many prophetic declarations.

Time and time again, we hear that the healing ministry of our Lord is not reserved for the wealthy few, but is intended for all of God's people. For instance, in Isaiah, the Lord proclaimed,

I will rejoice in Jerusalem, and delight in my people; no more shall the sound of weeping be heard in it, or the cry of distress. No more shall there be in it an infant that lives but a few days, or an old person who does not live out a lifetime; for one who dies at a hundred years will be considered a youth, and one who falls short of a hundred will be considered accursed . . . for like the days of a tree shall the days of my people be, and my chosen shall long enjoy the work of their hands

— Isa. 65:19–20, 22b, NRSV

Health care is a responsibility of both our public and private lives. Our love for God is reflected in our love for neighbor and in respect of ourselves. Jesus makes clear that a standard for judging all peoples has to do with how the least are doing in that community (Matt. 25:31–46).

Since John Calvin's hospital ministry in seventeenth-century Geneva, the Reformed tradition has expressed God's love through ministries of education and health care. This witness to God's concern has included individual and institutional responsibilities. At times, we have advocated and implemented this witness. Just a partial list of health-related actions of the Presbyterian Church (U.S.A.) demonstrates our continuing advocacy during the past four decades:

- 1960** — The Relation of Christian Faith to Health
- 1971** — Toward a National Public Policy for the Organization and Delivery of Health Services
- 1976** — Health Care: Perspectives on the Church's Responsibility
- 1978** — Health Ministries and the Church
- 1983** — The Report of the Task Force on New Directions in Health Ministries to the Divisions of International and Medical Benevolence Foundation
- 1986** — The Report of the Health Ministries Evaluation Team of the Program Agency Board
- 1988** — Life Abundant: Values, Choices and Health Care
- 1991** — Resolution on Christian Responsibility and a National Medical Plan.

In the ever-changing personal, national, and international world of health care, our church continues to advocate for and implement

examples of "covenant access to quality, affordable, preventive and curative health services." ■

Trends Affecting the Uninsured

Political Economic Trends

To be without health insurance in this country means to be without access to medical care. But health is not a luxury, nor should it be the sole possession of a privileged few. We are all created b'tzelem elohim—in the image of God—and this makes each human life as precious as the next. By “pricing out” a portion of this country’s population from health-care coverage, we mock the image of God and destroy the vessels of God’s work

— Rabbi Alexander Schindler,
Past President, Union of
American Hebrew
Congregations

The “Medical Insurance Complex” is a powerful and influential political voice throughout American society. Pharmaceutical companies, insurance corporations, biotechnology firms, hospital systems, professional medical and legal organizations—the list of special interests seems endless—have easy access to law makers. No major news magazine or newspaper appears without full-page advertisements for medicines and health insurance products. In fact, more money may be spent each year on

advertising, legal fees, and lobbying than on research and development of new drugs.

In contrast, persons without health insurance rarely have the opportunity to tell their stories to their elected representatives in local, state, and federal governments. In debates about universal health care, those on the margins need advocates to transform injustice into justice. To answer Jesus’ call for justice, advocacy is the first step needed to begin the uncertain journey for a just health-care system.

Among industrialized nations, health care in the United States is distinctive for its voluntary, profit-oriented features. No wonder that, in recent years, foreign drug companies have been buying controlling interests in several U.S. pharmaceutical firms. This consolidation has not reduced the cost of drugs or medical services—as demonstrated by the recent controversies between the U.S. and Canadian governments and



Switzerland-based Bayer over the anti-anthrax drug Cipro.

The cost of health care continues to rise at a rapid rate, much higher than the general rise in the cost of living. For instance, the Consumer Price Index for All Urban (CPI-U) consumers went from 134.8 in January 1991 to 175.8 in January 2001. The Medical Care component of the CPI-U went from 171.2 to 267.4 in the same ten-year period. The Prescription Drugs and Medical Supplies subcomponent of the CPI-U rose even more over the ten-year period, from 191.1 to 292.4, and the Hospital and Related Services

leaped during the same period from 188.8 to 327.9. According to Acs and Sablehaus (1995), “Increased health care spending was spread between households,

government, and business, with families absorbing 30 percent of the increase through direct out-of-pocket spending. Government accounted for 40 percent of the increase through higher budgetary outlays, primarily for Medicare and Medicaid. Businesses accounted for the remaining 30 percent of increased spending through non-wage compensation costs of labor.”³

The profits of companies in the health-care sector continue to

outstrip the performance of the stock market in general. The S&P 500 Index went from 343 in January 1991 to 1366 in January 2001—the greatest period of growth in the stock market’s history. During the same time, the adjusted stock price of one of the large drug companies (Eli Lilly, maker of the widely prescribed anti-depressant drug Prozac) jumped from \$19.23 to \$92.10. Another major drug maker (Schering Plough, maker of Benadryl) leaped from an adjusted stock price of \$4.50 to \$49.76 in the same ten-year period.

By the early 1990s, the

complexities of the health-care system in the United States were obvious to all observers. Phrases like “co-pays,” “denial of coverage,” “preexisting conditions,”

“exclusions,” “managed care,” “medigap,” “network and out-of-network,” and “safety net” became part of the American language. In recent years, they have been joined by acronyms like HMOs, PPOs, HCFA (recently renamed to CMA, Center for Medicare & Medicaid Services), CHIP, and COBRA. Often, these complexities lead to inequities, especially when knowledge of the health-care system is not shared uniformly among persons of diverse

The profits of companies in the health-care sector continue to outstrip the performance of the stock market in general.

age cohorts, ethnic and linguistic groups, and socioeconomic classes.

According to Bernard T. Ferrari M.D., J. D., a senior partner at McKinsey & Co., “the cost structure of managed care is roughly 85 percent medical and 15 percent overhead” (*Managed Care*, available at <http://www.managedcaremag.com/archives19910/9910.consolidate.html>)

. In contrast, federally guaranteed programs such as Medicare spend less on overhead (about 2 percent) and more on patients’ health. The increase in the number of health administrators is more than twice the increase in the number of physicians in recent years.

In the campaigns for the 1992 elections, the problems of rising costs and inequities of coverage made universal access to health care a national issue. The Clinton Administration made its health plan a showpiece, but intensive lobbying by many special interests led to its rejection by Congress. In the aftermath of this rejection, Congress cut federal funding for Medicaid, with negative impacts on poor and immigrant populations, and has tried to privatize and “individualize” Medicare. During the decade of the 1990s, the consolidation of the health-care industry has resulted in the disappearance of many formerly nonprofit (often church-related) community health-care systems. The changes during the 1990s were accompanied by a steady increase in the numbers of persons without



health-care insurance. The impact on individuals and their families has been costly beyond measure. It is estimated that nearly half of the more than one million Americans who filed for personal bankruptcy in 1999 made this difficult decision at least in part because of debts associated with catastrophic health problems. Health-care expenditures now constitute almost one-seventh (14 percent) of our country’s gross national product. Health-care costs now exceed \$1 trillion, and (even in the midst of a national recession, mergers, downsizings, and layoffs) health-care companies continue to be among the most profitable companies in the country (National Coalition for Healthcare, “Health Care Facts: How Much Do We Spend?” www.nchc.org/know/spending.html).

Recent economic trends have worsened the uninsurance crisis. The softening of the U.S. economy has been seen in the sharp declines in the stock markets since mid 2000. The Federal Reserve Board of Governors has been combating fears of recession by lowering interest rates throughout 2001. The Discount Rate has been slashed from 6.0 percent to just 2.0 percent through ten separate rate cuts, but the economy barely seems to respond—especially in the wake of the tragic events of September 11, 2001. The nation’s unemployment rate, which had reached all time low levels during 1999, jumped to 5.4 percent during October 2001. The laying off of hundreds of thousands of workers in the transportation industry (airlines, hotels, restaurants, travel agencies, etc.) comes on top of earlier layoffs of similar magnitude in telecommunications and other New Economy (“dot com”) ventures. Many of these workers have been eligible for short-term, self-financed continuation of their health insurance, but when their “COBRA” benefits come to an end millions of individuals and their families will have been added to the roles of the uninsured. The high costs of paying the premiums (about \$2,650 for an individual and \$7,053 for a family) result in fewer than 20 percent of COBRA-eligible workers electing this option. Newly unemployed workers must choose between food,

rent, and clothing versus health insurance; it is hard to be concerned about the future when today must be faced. President Bush’s proposal to make \$3 billion in emergency aid available to workers laid off in the wake of the events of September 11 pales in comparison to the \$15 billion airline industry aid plan.

Denominational and Ecumenical Trends Related to the Uninsured

Every person has the right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all persons, who are made in the image of God. . . . Our call for health care reform is rooted in the biblical call to heal the sick and to serve “the least of these,” the priorities of justice and the principle of the common good. The existing patterns of health care in the United States do not meet the minimal standard of social justice and the common good.

—Resolution on Health Care Reform, U.S. Catholic Bishops



Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

—The Universal Declaration of Human Rights Article 25 (1)

Following its 1988 statement on *Life Abundant: Values, Choices and Health Care* (Minutes, 1988, Part I, pp. 517–47), the PC(USA) continued to be an advocate for the persons marginalized in the national debate on health uninsurance. The *Resolution on Christian Responsibility and a National Medical Plan* (Minutes, 1991, Part I, pp. 810–20) appeared just as the political agenda on health care was being established for the 1992 national elections. But the Presbyterian church had not been the only denominational voice crying in the wilderness for health-care reform during the 1990s. For example, several other denominations staked out their national commitments to universal health care during the 2000 political season:

- The Catholic Health Association of the United States and the American College of Physicians-American Society of Internal Medicine worked together on their own “Campaign 2000” to develop a national dialogue to make accessible and affordable health care a national priority.
- The United Methodist Church, through its Program for Health and Wholeness at the General Board on Church and Society, also is dedicated to the proposition that health care is a right, even though our culture treats it as a commodity to be offered only to those with resources. According to the Reverend Jackson Day, the program director, “the story of the Canaanite woman reminds us that health care must be for all, and we must find ways to realize that in our society” (Matt.15:21–28).
- In 1999, the Churchwide Assembly of the Evangelical Lutheran Church in America (ELCA), approved a resolution to authorize preparation of a draft of an ELCA Social Statement on Health and Ethical Issues in Health Care for presentation at the 2003 Churchwide Assembly. This statement will focus on four points:
 - presenting a Lutheran vision of health and health care;
 - dealing with the issues of access to health care and equity in health care;
 - addressing the mission and ministry issues of health care institutions related to the ELCA; and
 - assessing the role and promise of ELCA congregational health ministries now and for the future.

Most campaigns concerned with the uninsured and the more general issue of universal health care are aimed at convincing elected officials at the federal level to pass legislation to create a more equitable system to replace the current combination of employer-based, government-funded, and private-insurance plans. Nevertheless, efforts to deal with the situation exist at all levels of American society, from specific communities to states to the nation at large. We offer three examples to demonstrate the breadth of ecumenical involvement in these campaigns:

The Local Level

An example of local initiatives comes from Chicago. In 1999, a coalition of religious, labor, and community organizations launched a campaign to raise \$100 million a year to provide medical care to the growing number of uninsured in the metropolitan area. Calling its effort the Gilead Campaign, United Power for Action and Justice (associated with the Industrial Areas Foundation) hopes that this network of public and private organizations can cut in half the number of uninsured in the Chicago area. To accomplish this goal, \$100 million annually will be needed to provide health-care access to 400,000 individuals, who represent only half the area's estimated number of people without coverage.

The State Level

Several states have taken leadership roles in dealing with health issues related to the uninsured. Here we cite two well-known examples, one from the west and the other from the east.

In Oregon, the "Oregon Health Plan (OHP)," launched through legislation passed in 1989, blends managed care and benefit limitations to provide Medicaid-linked coverage for state residents according to a prioritized list of services. As Richard Conviser's "Brief History of the Oregon Health Plan and its Features," points out: "The most immediate result of Oregon's reform effort was that many residents who previously had no health insurance gained such coverage." (This document is available on the Internet at www.ohppr.state.or.us/docs/pdf/histofplan.pdf). A subsequent study of "The Uninsured in Oregon 1998" (prepared by the Office for Oregon Health Plan Policy & Research) suggests that the Oregon Health Plan "has increased access to health care for thousands of previously uninsured Oregonians. Between 1990 and 1996, implementation of the OHP, in conjunction with a strong economy and a private-sector commitment to providing health insurance coverage, resulted in a reduction in the proportion of uninsured individuals from 18 to 11 percent." (This report is available on the Internet at

www.ohppr.state.or.us/docs/pdf/uninsured.pdf).

In Maryland, a coalition of faith-based groups, ranging from congregations to denominations, have introduced a “Declaration of Health Care Independence” that calls for quality, affordable health care for all state residents. Speaking on behalf of groups such as the Episcopal, Lutheran, Methodist, and Presbyterian churches, the Baltimore Jewish council, and the Baltimore Board of Rabbis, the Reverend Arnold Howard (of the Interdenominational Ministerial Alliance and the Greater Baltimore Clergy Alliance) declared, “Quality health care ought not to be a privilege for the few but a right for everybody.”



The Federal Level

Designed to place universal health care on the political agenda for the 2000 elections, the U2K campaign had 400 endorsing faith-based and community-based organizations. Founded in October 1999 by the National Council of Churches, the Universal Health Care Action Network, and the Gray

Panthers, U2K mobilized the ecumenical faith community to back its efforts toward achieving “comprehensive, affordable, quality, and publicly accountable health care for all.”

All of these advocacy efforts—whether at the local, state, or federal level—are intended to combine short-term “fixes” to the present piecemeal health-care system with a longer focus on the future creation of a universal national medical plan. In this sense, our denomination has continued to labor in the light of the policy statements of 1988 and 1991. The 207th General Assembly (1995) approved “Call to Healing and Wholeness: A Review of the Presbyterian Church (U.S.A.)’s Health-Care Policy and Program with Recommendations” (*Minutes*, 1995, Part I, pp. 35, 459–82). One of the recommendations in the 1995 resolution required that a “monitoring report” be prepared by the Advisory Committee on Social Witness Policy for submission to the 211th General Assembly (1999). One of the conclusions of this monitoring report is that “Several entities of the General Assembly have been actively advocating for health-care delivery systems for all persons” (p. 12). In particular, the church has been a participant in the National Coalition on Healthcare and has worked through the Presbyterian Washington Office with lobbying groups such as Families USA and the Alliance for Health Reform.

Health Trends

We don't really want cars—we want transportation.

We don't really want telephones—we want to communicate.

We don't really want light bulbs—we want light.⁴

And we don't really want health insurance—we want health.

The health care system in America is not in the same place as it was before the terrorist attacks of September 11, 2001, amid continuing threats of anthrax and contagious diseases. Health care needs are now entangled in the fiercely partisan debate over the economic stimulus package in the Senate. Democrats are backing a plan that would provide \$9 billion to cover 75 percent of the premiums for those persons who have lost their jobs since September 11 and are trying to keep their private insurance. The plan would also provide \$5 billion to increase the federal contribution to Medicaid, and another \$3 billion for states that want to help unemployed workers without coverage and not otherwise eligible for assistance. The Republican position is that the plan

is too costly, is not focused sufficiently on the neediest Americans, and runs the risk of creating an expensive new entitlement, even though the premium assistance is limited to just over a year.

With the debates only beginning at this time, we need to be advocates on behalf of vulnerable persons, especially those with low incomes and fixed incomes. The health system is being directly affected by the economic slowdown of 2000–2001, and the situation has worsened since September 11, 2001. For example, thousands of workers daily are being let go from work. They may have temporary health insurance in place,

With the debates only beginning at this time, we need to be advocates on behalf of vulnerable persons, especially those with low incomes and fixed incomes.

as long as they can afford to pay the full premiums as specified under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the 1986 law designed to provide a bridge for workers between jobs. The

COBRA has been used by millions of workers, but it has serious limitations; for example, it does not apply to persons who work for businesses with fewer than twenty employees. Because persons able to afford the premiums mandated by COBRA tend to be more affluent, they rarely qualify for other public programs aimed at the health of

parents and their children. To compound the problem, lower-income individuals without children are not eligible for coverage under the CHIP programs and cannot afford the COBRA premiums.

It is urgent to understand that being uninsured is not a status of a certain class of citizens in our society. It is a condition that may affect anyone at any time. For instance, for retired persons with fixed incomes “end of life costs” can be a special burden. When Medicare funding has been exhausted, caregivers must pay for all services. Depending on the severity and duration of illness, a long and costly list of hospital and medical services may not be covered (e.g., days beyond the “lifetime” limit for hospital care and oxygen equipment for lung and respiratory illness).

Even workers who participate in employer-based medical insurance plans may not be covered for certain important kinds of health care (e.g., eye care, dental care, psychiatric care). As long as health insurance continues to be employer based, the uncertainty of employment means that access to health-care benefits may vary at alarming rates. In this national context, the advocacy on behalf of the uninsured is essential.

Uninsured Americans have posed a challenge for public-sector health systems as states attempt to find ways to address physical and behavioral health needs for a population that frequently delays seeking care until a condition requires hospitalization. Several

behavioral health programs, such as those in the states of Arizona and Tennessee, and in the city of Dallas (Texas) have struggled with the dynamics of trying to serve this population under capitated managed care systems.

The following table⁵ offers a profile of the 44.3 million uninsured persons by income as a percentage of the federal poverty level (FPL)⁶:

less than 100% FPL	26.1%
100%-150% FPL	16.8%
150%-200% FPL	14.0%
200%-300% FPL	18.3%
300% FPL or more	24.8%

In a CHIP document entitled “Healthy Families: Family Health Insurance through One Door, March 2001—Recommendations for Creating a Unified Health Insurance Program for California’s Children and Their Parents,” the 100% Campaign (a collaborative of Children Now, Children’s Defense Fund, and The Children’s Partnership Insure the Uninsured Project, with funding from the California Endowment and the California Wellness Foundation) states:

... By submitting a “waiver request” to federal officials, California became one of the first states to develop a plan for using available federal [funds to support its] State Children’s Health Insurance Program (SCHIP). . . . But one consequence of this proactive approach is that

California's residents now face a daunting add-on-collection of programs and policies built over many decades. And while each piece has valuable objectives, the cumulative effect is a maze of inconsistent, redundant, and inconvenient rules that discourage parents and their children who want and need health care. In addition, the fragmented approach to health coverage has continued to leave many working parents uninsured.

The issues of unequal access to quality health care are not only visible among low-income and fixed-income individuals, but also appear among the large populations of immigrants who have come to our nation in recent decades. In November 2000, the Henry J. Kaiser Family Foundation funded a publication on "Immigrants' Access to Health Care after Welfare Reform: Findings from Focus Groups in Four Cities." Prepared by Peter Feld et al., the conclusions section of this publication merit our attention:

Many immigrants arrive in the U.S. to a very different world—faced with challenges in adjusting to a new and complex society where systems of health care coverage and access to services may be very different from their native countries. The complexity of the policy environment compounds the difficulties facing new arrivals to this country. Recent policies treating new

immigrants differently from both current immigrants and citizens create additional confusion and complexity for immigrants who need Medicaid and other public benefits. Additional factors such as language, poverty, country of origin, discrimination, and type of employment also contribute to immigrants faring poorly in regard to health care coverage and access. As policymakers discuss the nation's growing number of uninsured and issues of access and quality, the plight of the non-citizen U. S. population will need to be addressed.

Clearly, the church and our thousands of congregations must be educated about the continuing importance of the 1991 "Resolution on Christian Responsibility and a National Medical Plan." The need to understand the new dynamics of health care in the twenty-first century is even more demanding. Only with help from religious organizations, health-care institutions, professional medical organizations, and even the insurance industry will the nation's legislative leadership be willing to pursue the goal of establishing a National Medical Plan. We ask congregations, middle governing bodies, and the denomination to consider the new context for Paragraphs 40.021 and 40.022 of the 1991 Resolution, which establish, at the highest levels of society, the basis for advocacy for the uninsured. ■

The Challenges

*“I came that they may have life,
and have it abundantly”*

— John 10:10b

Data from the 2000 U.S. Bureau of Census estimate that there are 42.6 million Americans who are uninsured at any one time, a number that has risen by 8 million (20 percent) since 1990 (*Executive Memorandum June 4, 2001, #750*).

This is frightening! The word “uninsured”

drives terror into us because of the connotation of insecurity and fear. This is how nearly 43 million of our fellow-citizens are living—with a sense of insecurity and uncertainty about

their future, their health, and their well-being. A catastrophic illness could drain the savings of those with some resources, but for the poor, it becomes a traumatic event because of the added inability to gain access to quality treatment.

The challenge and the goal of our nation ought to be access to quality health care for everyone within its borders. We believe that it is the moral responsibility of the state to ensure that all its peoples enjoy access to quality health care.

“Quality” health care should not be

The Challenges

reserved for the privileged. It is a right for all. With the proliferation of hospitals and the large number of practicing doctors, quality care can be available to the entire community. It is also the Christian responsibility in keeping with Christ’s threefold instructions to Peter, as the representative of the Church, that he should “feed my lambs,” “tend my sheep,” and “feed my sheep” (John 21:15–17).

Without proper health care, our nation is losing the benefit of human

resources and the economy is being robbed of potential contributors. We need to realize that failure to ensure access to quality health care for the 42.6 million uninsured can have a serious

domino effect. Not only are entire families affected negatively, but also the entire nation is at risk in the event of an epidemic. By providing quality health care for the uninsured, we are not just preserving the life of poor individuals, we are protecting the health of the entire nation.

In pursuing the goal of accessible health care for the uninsured, we cannot discriminate as to who should be the recipients of our services. We cannot discriminate on the basis of color, class, race,

We need to realize that failure to ensure access to quality health care for the 42.6 million uninsured can have a serious domino effect.

ethnicity, religion, or nationality. We cannot discriminate on the basis of the documented or the undocumented.

The goal must be quality care for all people, irrespective of their ability to pay, their status, or their place of origin. As one of the richest nations of the world, blessed with both medical practitioners and medical resources, America needs to assure universal health care for all. This is a service that can be delivered with the resolve of our political leaders, with the desire for equity, with the social

consciousness of the corporate sector, with proper planning, and with the compassion of caregivers.

As we seek to realize our goal of accessible health care for all, one of our priorities must be informing the public of the services that are available. Publicity and promotion are important aspects of accessibility. Too many programs are underutilized because many of the targeted people are not aware of the resources available to them. We live in a pluralistic society with a multiplicity of languages, and with many people not conversant in English. This is indeed a challenge. It is incumbent upon us to develop an effective communications network so that government

programs available for the uninsured are publicized.

Another important challenge as we address the issue of accessible healthcare for all is the need to remove the threat of penalties and thereby dispel the fear of reprisal from some sectors of the community, including the undocumented. Because of the fear of reprisals, many uninsured persons are unwilling to utilize available services. For instance, many members of the undocumented immigrant community believe that

they could be reported to other arms of the government and ultimately deported. We need to assure all persons that there will not be a betrayal of their privacy and that their legal status will not be

disclosed. Care must be given to ensure and maintain a sense of confidentiality.

A third challenge is that some individuals may feel robbed of their dignity or personal pride if they utilize services for which they are unable to pay. This loss of dignity can be worsened if service providers fail to demonstrate respect and sensitivity or deliver inferior services because they are aware of the circumstances of the recipients. We need to maintain equally

The goal must be quality care for all people, irrespective of their ability to pay, their status, or their place of origin.

professional standards of care for the insured as well as the uninsured. The uninsured must have confidence in the quality of the care they receive from public programs. We cannot allow the most vulnerable in the community to hesitate to seek treatment because they are in doubt and fear of the quality of the care they will receive. Clinics, hospitals, and other health-care providers must serve all people faithfully.

Another challenge to accessible health care is the escalating cost of prescription drugs and health services in general. Health care needs to be affordable for both the uninsured and also the underinsured.

Many people who have insurance are finding out that their coverage is not adequate to meet the cost of the medicines they need. Since Medicare does not cover prescription drugs, and since the cost of pharmaceuticals has increased dramatically in recent years, many older adults and others on fixed incomes must choose between paying for food or for medicines—because they cannot afford both.

The Challenges

Individuals in need of health care are already in difficulty. Their health is in jeopardy. They may be facing disability or may be aged and on a fixed income. Their resources may be limited and in danger of being drained away as they purchase medicines to maintain their health. Their economic situation is threatened and the quality of their lives is diminishing. The issue of their mortality is real. It is immoral that some corporations prey on and exploit these individuals with the desire for profit. The situation is made worse when the government becomes an unwitting accomplice because of misplaced priorities or acquiescence to the pressure of interest groups so that they fail to subsidize or control the price of drugs.

The country needs to examine the high cost of drugs and make them more affordable for the community. We call to question whether drugs are being sold in accordance with the cost of production or with the profit motive at work in our capitalist society. Those at risk in the society should not have to choose between drugs or food, or have to

Those at risk in the society should not have to choose between drugs or food, or have to travel to other countries to purchase drugs at a lower cost, or ask that drugs be re-imported so that they can become more affordable.



travel to other countries to purchase drugs at a lower cost, or ask that drugs be re-imported so that they can become more affordable.

“(Jane Public) is among scores of older Americans who have headed across the border by the busload to buy cheaper medicines. A drug she takes to lower cholesterol, Zocor, is just \$60 for a month’s supply in Canada. At home she pays \$101” (*New Jersey Star-Ledger*, Sunday, 10/15/00, Page 19, Section: News Edition).

“Prescription drugs can cost three to four times less in Europe and Canada than they cost in the United States. For example, a 30 day supply of Claritin, an allergy medication, costs \$63 in the United States, compared with \$16 in Europe, according to the Life Extension

Foundation, an advocacy group” (*New Jersey Star-Ledger*, Thursday, 7/12/01, page 004).

The above two articles beg the question as to why, both in Canada and Europe, drugs can be obtained more cheaply than here in the United States where most of them are manufactured. Who is benefiting from the high cost of prescription drugs? And why should the uninsured and under-insured be the losers? The affordability of drugs for the poor and uninsured in the country is being called to question!

For an ultimately healthy society, the United States is being called upon to provide access to quality and affordable health care for the uninsured. This access must be without discrimination and must ensure the dignity of all people. ■

Endnotes

1. Federal tax credits would not be a helpful method to address the health needs of the uninsured due to the fact that many low-income individuals do not file tax returns anyway. [This endnote can be found in the recommendations.]
2. Estimating the number of uninsured persons in the United States is difficult because the U.S. Bureau of the Census, the federal agency with the primary responsibility for gathering these data, recently changed the key question in the Current Population Survey (CPS) used to determine uninsured status. Before March 2000, the question asked if someone in a household was covered by insurance at any time during the previous year. After March 2000, the question was changed to ask if a person in a household was uninsured throughout the previous year. The result of this rewording has lowered by more than a million the number of "uninsured" persons reported in official statistics. All analysts agree that at least 40 million persons living in the U. S. currently are uninsured. Thus, different figures appear in different reports. Some of the variation is a function of the actual change in the number of uninsured persons in different surveys and some of the variation is a result of the rewording of the question.
3. Acs, Gregory and John Sablehaus (1995) "Trends in Out-of-Pocket Spending on Health Care, 1980-1992," *Monthly Labor Review*, Vol. 118, No. 12 (December), pp. 35-45.
4. Cox, W. Michael and Richard Alm (1997) "The Economy at Light Speed," p. 12. Dallas, Texas: Federal Reserve Bank of Dallas, *1996 Annual Report*.
5. "A look at the uninsured." *Mental Health Weekly* (May 15, 2000) vol. 10, i. 20, p. 6 [this article summarizes the March 1999 Current Population Survey data, as reported by the Alliance for Health Reform.]
6. The Federal Poverty Level is based on data gathered by the federal government but each state sets the percentage of the FPL required to be eligible for state and federal programs within that state. Some states use 100 percent of FPL, but others use 125 percent, 150 percent, and so forth. ■



Recommendations

- 1.** Reaffirm past policy statements and resolutions related to health-care issues [e.g., *Life Abundant: Values, Choices and Health Care: The Responsibility and Role of the Presbyterian Church (U.S.A.)*, 200th General Assembly 1988; Resolution on Christian Responsibility and a National Medical Plan, 203rd General Assembly (1991)].
- 2.** Reaffirm the church's commitment to advocacy for a national medical plan [Resolution on Christian Responsibility and a National Medical Plan, *Minutes*, 1991, Part I, pp. 810–20].
- 3.** Encourage the church to recognize and sustain the efforts of safety-net organizations, including clinics and pharmacies, dedicated to meeting the health needs of the uninsured.
- 4.** Reaffirm the church's commitment to advocacy at all levels on behalf of low-income and fixed-income immigrant populations who lack health insurance.
- 5.** Encourage presbyteries, sessions, and the members of congregations to be advocates for universal health care and to support advocacy efforts in their local communities to bring public and private entities together in this effort.
- 6.** Urge presbyteries, sessions, and the members of congregations to be mindful of our church's health policy statements and to establish employment practices to cover all employees (including part-time employees).
- 7.** Urge presbyteries, sessions, and the members of congregations to celebrate Health Awareness Week each year and to give emphasis to the need for universal health care in our nation.
- 8.** Urge presbyteries and sessions to provide educational programs and advocacy efforts on behalf of persons, especially those with low incomes and fixed incomes, without medical insurance.
- 9.** Urge the Office of Health Ministries USA, in consultation with the Presbyterian Washington Office and other appropriate entities, to produce advocacy materials in appropriate languages on behalf of medically uninsured persons, particularly those with low incomes and fixed incomes. These advocacy materials should be ready for distribution to congregations before the Health Awareness Week of 2003.
- 10.** Urge the Rural Ministry Office (Evangelism and Church Development) to give special attention to issues of access to and cost of health care in rural communities, particularly among persons with low incomes and fixed incomes.

11. Direct the Presbyterian Washington Office to advocate the following:

a. Urge adequate funding for the Children’s Health Insurance Program (CHIP) so that health-care coverage will be available for all children.

b. Urge the expansion of CHIP legislation to include the parents or caregivers of children covered under its provisions.

c. Oppose federal tax credits as a method to address the health needs of the uninsured.¹

d. Urge the expansion of Medicaid to insure more low-income and fixed-income persons, including the recently unemployed.

e. Encourage members of the Congress to recognize the importance of universal health care—that is, equal, accessible, affordable, and high-quality health care for all persons residing in our nation.

12. Encourage the Mission Responsibility Through Investments (MRTI) to review health policies of the corporations in which the church makes investments and to advocate for universal health-care coverage for employees at all levels.

13. Urge the Advocacy Committee for Women’s Concerns (ACWC) and the Advocacy Committee for Racial Ethnic Concerns (ACREC)

to advocate on behalf of low-income and fixed-income persons who lack health insurance.

14. Encourage Presbyterian Church (U.S.A.) seminaries, through the Committee on Theological Education, to deal systematically with health-care issues, especially in the context of courses focused on social justice, community ministry, and congregational care, as well as by ensuring that all students and their dependents have access to affordable, comprehensive health-care coverage.

15. Urge the Board of Pensions (BOP) to make available health coverage to all church employees (including part-time (20 hours or more) employees) so that the church can serve as a model to other organizations in the nation for offering universal health-care coverage. ■



Appendix I

The Challenge to Presbyterians from the 214th General Assembly: Adequate Health Care for Everyone

As Presbyterians, we are called to promote justice and equity, to engage in healing and to treat one another with compassion. Historic inadequacies in our health care system and the distribution of services through that system leave millions without the means to obtain even the most basic health care for themselves and their families. While continuing escalation of health care costs affects all of us, the affect on the most vulnerable is devastating. Individuals on fixed incomes become at greater risk. People (and their families) who have lost jobs and benefits due to the economic downturn are at risk. Individuals without private coverage or who do not qualify for government subsidized insurance are at greater risk than before because the numbers of health care providers willing to give treatment to medically indigent people are decreasing at an alarming rate. Rising co-payments and deductibles combined with stricter pre-authorizations and reimbursement

caps are affecting health care access for middle-income persons.

Presbyterians and other people of faith cannot achieve health care justice without legislative action. The church must provide not merely a moral whisper of conscience, but a chorus of voices raised in a call for immediate action. These voices must overcome the special interest

groups' rationale.

These voices must speak for those who feel they will not be heard. These voices must emanate from every church and each community.

Congregations and individuals can become the catalysts for change - once they are aware of the increasing climate of crisis in our health care system, and, once they have become aware of effective legislative solutions. They will need to bring together concerned people to create networks of health care advocates who will share information, lobby their elected officials, and add their voices to the public policy debate already begun.

The church must provide not merely a moral whisper of conscience, but a chorus of voices raised in a call for immediate action.

Where does one begin? The process is very straightforward.

1. Interact with your local congregation by raising the general awareness to the crisis in health care. Be certain to point out that health care access not only affects the uninsured, but those insured people who are continuing to pay more for health care through rising co-pays and deductibles, stricter pre-authorizations and reimbursement caps. If you have health care providers in your congregation they might be willing to share some of their own frustrations with the health care system. Look for opportunities to inform the members of your congregation of the crisis in health care. You might:

- Write an article for your congregation's newsletter or bulletin
- Sponsor a study of scriptures which call the community of faith to concerns of healing and justice.
- Request that health care issues be the topic of sermon(s).
- Use Moments for Mission in worship.

If you have health care providers in your congregation they might be willing to share some of their own frustrations with the health care system.

- Make a presentation to the Session.
- Make a presentation to the health/mission/outreach/social concerns committee.
- Make presentations to existing identity groups in the congregation.

2. Reach beyond your local congregation. After gathering a few members of your congregation who are interested in health care reform, extend your coalition to other Presbyterian congregations by requesting time at Presbytery or Synod gatherings and leadership events to both raise awareness and engage others in the coalition you are

building.

Look for allies among other people of faith. Social justice issues resonate among reformed tradition faith groups. Invite their participation. Urge them to educate and enlist others. Make use of your natural contacts. Find out if an ecumenical or interfaith organization in your state is already involved in universal health care advocacy. Establish contact with the social action and advocacy or health ministries staff who serve in

coordinating structures in your state and national offices.

For each person you add to your coalition, systematically identify the components of his or her “sphere of influence.”

3. Identify and collaborate with existing organizations working for Health Care Access.

In many states, groups are now working to pull people together for health advocacy. Contact them and find out whether you

In many states, groups are now working to pull people together for health advocacy.

can work with them. They may be able to provide you with materials and information updates for your group. Find out, also, whether there are local contacts or organizations working in your local community for universal health care. If not, form a coalition.

4. Remember the concept of “enlightened self interest.”

Health care costs affect everyone, so rule out no one as you build your coalition. Brainstorm lists of local organizations that have any reason to be concerned. Many members of your congregation also belong to other organizations, unions, neighborhood groups, etc. Today, employers and health care providers are beginning to call for reform. Again, make use of contacts you already have to build

your coalition of concerned advocates.

5. Inform and Alert your community.

Look for opportunities to raise the awareness of your entire community. Use data from and illustrations of the crisis in health care provided here and from the

resources listed at the end of this section to plan awareness programs. Form a speaker’s bureau from your coalition and contact civic and business

organizations (this is a great time to utilize “sphere of influence” information from your coalition members.)



6. Communicate your expectations to your elected officials AND hold them accountable. For universal health care access to be adequately and comprehensively addressed, legislative action is necessary. Know the names of your elected officials and take every opportunity to meet and speak with them. While many elected officials take seriously the will of their constituents, they do not actively solicit the opinions of those who have elected them. Be certain the legislators who represent you are aware that you expect them to work for health care access and that you (and your group) will track their voting on legislation pertaining to this issue.

Additional resources for advocacy efforts on Universal Health Care Access are available on the Health Ministries USA website – www.pcusa.org/health/usa. These resources include links to the PC(USA) Washington office, to other organizations that have joined in the effort, and to legislative tracking entities. You will also find downloadable posters and graphics and an increasing number of materials designed specifically for congregations by among others, the Presbyterian Health Network (of PHEWA). Please check the website often as it will change frequently. Printed advocacy materials can be obtained by calling 1.888.728.7228, ext 5550, or by sending an e-mail to health@ctr.pcusa.org.



Appendix II

Health Care Access Resolution Or House Concurrent Resolution 99: Directs Congress to enact legislation by October 2004 that provides access to comprehensive health care for all Americans.

The legislation text is as follows:

- Whereas the United States has the most expensive health care system in the world in terms of absolute costs, per capita costs, and percentage of gross domestic product (GDP);
- Whereas despite being first in spending, the World Health Organization has ranked the United States 37th among all nations in terms of meeting the needs of its people;
- Whereas 43 million Americans, including 10 million children, are uninsured;
- Whereas tens of millions more Americans are inadequately insured, including medicare beneficiaries who lack access to prescription drug coverage and long term care coverage;
- Whereas racial, income, and ethnic disparities in access to care threaten communities across the country, particularly communities of color;
- Whereas health care costs continue to increase, jeopardizing the health security of working families and small businesses;
- Whereas dollars that could be spent on health care are being used for administrative costs instead of patient needs;
- Whereas the current health care system too often puts the bottom line ahead of patient care and threatens safety net providers who treat the uninsured and poorly insured; and
- Whereas any health care reform must ensure that health care providers and practitioners are able to provide patients with the quality care they need:



- Now, therefore, be it Resolved by the House of Representatives (the Senate concurring), that the Congress shall enact legislation by October 2004 to guarantee that every person in the United States, regardless of income, age, or employment or health status, has access to health care that —
1. **is affordable to individuals and families, businesses and taxpayers** and that removes financial barriers to needed care;
 2. **is as cost efficient as possible**, spending the maximum amount of dollars on direct patient care;
 3. **provides comprehensive benefits**, including benefits for mental health and long term care services;
 4. **promotes prevention and early intervention**;
 5. **includes parity for mental health and other services**;
 6. **eliminates disparities in access to quality health care**;
 7. **addresses the needs of people with special health care needs and underserved populations in rural and urban areas**;
 8. **promotes quality and better health outcomes**;
 9. **addresses the need to have adequate numbers of qualified health care caregivers, practitioners, and providers** to guarantee timely access to quality care;
 10. **provides adequate and timely payments in order to guarantee access to providers**;
 11. **fosters a strong network of health care facilities**, including safety net providers;
 12. **ensures continuity of coverage and continuity of care**;
 13. **maximizes consumer choice of health care providers and practitioners**; and
 14. **is easy for patients, providers and practitioners to use and reduces paperwork**.

