# Letter from Members of Trinity Episcopal Church Advocating the Reform of our Healthcare System

> I have observed the misery of my people . . . ;
> I have heard their cry. . . .
> Indeed, I know their sufferings,
> and I have come down to deliver them (Exod 3:7f).

The joys and the sufferings of our neighbors, and more especially of our brothers and sisters, cannot leave us indifferent. Thus it is that those of us at Trinity Episcopal Church (Troy, Ohio) have taken the time to reflect on the suffering experienced by those forty-three million Americans who have no health insurance and upon untold others who fear that their health insurance would be inadequate should a medical emergency strike a member of their family. Our hearts especially go out to those who have needlessly died due to their inability to pay for needed medical treatment and to those who have lost their family home or filed for bankruptcy in order to pay for medical treatment.[1]

This prophetic letter represents one of the means some members of Trinity Episcopal Church have employed to respond to the General Convention resolution (A079) calling upon us to explore and to advocate a system that will provide "decent and appropriate primary health care for all citizens." Dr. B. Mark Hess, M.D., met with twenty-five members of our parish in a voluntary adult forum on January 4th and 10th for the purpose of exploring our healthcare system and contrasting it with systems found elsewhere. This letter expands upon and renders specific how our concerns for the suffering of the uninsured reflects God's concerns in this matter and reflects our intent to live the Gospel of Jesus Christ.

## Statement of the Problem

The resources of healthcare within our society are not fairly distributed. Those who have access to health insurance supplied by their employer know full well that their ability to provide routine and emergency medical attention to members of their family depends upon the fact of their employment. On the other hand, given the fact that health insurance for a family costs more than $6000 annually, many employers have resorted to requiring their regular employees to work overtime or hire "temps" in order to avoid the insurance cost of hiring a new employee.[2] On the other hand, even established companies are adapting cost-shifting strategies to transfer more of the rising costs of healthcare to the employees. At the same time, low paying jobs in supermarkets and fast food chains are generally filled by young persons insured by their parents or by the elderly who are insured by Medicare. Eighty percent of those uninsured are minors living in their family home or are adults working full-time outside their home.[3]

Some persons urgently need employment, decide to take low paying jobs, and risk living without health insurance. Some graduates from college fail to find employment following graduation. They live without health insurance or their parents borrow money to buy them insurance. Many are forced to take whatever employment is available and to give up, for the time being, the dream of being employed in the profession in which they were trained.

Some persons urgently need employment and decide to take low paying jobs, and risk living without health insurance. Forty percent of the uninsured earn less than $20,000 per year. Such persons, given their low take-home pay, live a hand to mouth existence that necessitates putting off

dental or medical care whenever possible. Their health and that of their dependents are thus calculated to decline because they are caught in the continuous pressure of being unable to make ends meet. Younger families with low incomes are thus at risk. A new father admits that his wife put off visiting a doctor until her pregnancy was well into the eighth month because she wanted to safeguard their savings of $800 that was set aside to pay for the delivery. In such instances, the lack of insurance and the limit on funds places the health of the mother and that of her newborn baby at risk. Studies show that small amounts of routine medical care for pregnant mothers and their offspring often serve to offset huge expenses later on. When mothers are scrimping and scraping to make ends meet, however, they often choose to risk the future by safeguarding the present.

The elderly with low fixed incomes have to decide whether to pay for needed drugs or to buy good food. A gray-haired woman functioning as a part-time cashier at a local drug store tells how she needs employment to be able to pay for the costly drugs needed to arrest her husband's nervous disorder. Meanwhile, while working, she confesses that she is anxious lest her feeble husband fall down and injure himself while she is away and unable to offer him the assistance he requires. It does no good to tell such persons that they now have the opportunity to enroll in a prescription drug insurance plan provided by an HMO. Given the prior conditions of those to be insured, the elderly on low fixed incomes do not have the assets that would allow them to enroll. Furthermore, the elderly understand that HMOs are in the business of staying in business and therefore have to severely limit their "charity cases" where they lose money. The peace of mind provided from such plans, therefore, only serves the moderately rich who have sufficient assets to pay the required premiums. This is also true for health savings plans. Those others have to live with the anxiety and insecurity that accompanies the infirmities of growing old in America.

The United States is the only industrialized country where medical insurance is regarded as a benefit of employment. In this system, employees lose this benefit as soon as they are laid off. Accordingly, at the very time when unemployment compensation abruptly reduces their income by half, families have to decide whether to scrimp in order to pay monthly insurance premiums on a Cobra Plan or to put their family at risk by dropping health insurance. If they decide to shop around for a less expensive health insurance plan, they quickly discover that insurance companies are in the business of making profits and they routinely refuse to insure persons with a history of poor health or a disposition toward cancer or kidney failure. Even persons in perfect health quickly discover that they can pay less for an insurance plan but their coverage would be only a fraction of what they formerly enjoyed as part of a group plan.

Because of the lack of insurance as well as the deductibles and co-payments required by even the best of HMOs, many persons are prompted to ignore their symptoms and, as things get chronically worse, to scramble around for a free clinic at the last moment. Dr. Bob LeBow tells the story of a 24-year-old mother of two who had insurance but, fearful of the out-of-pocket costs, delayed finding a doctor until her persistent fever and weakness were beyond her endurance.[4] She died needlessly of an easy-to-treat bacterial heart infection the next day. A study by the Institute of Medicine shows that 18,000 people die needlessly each year because, for financial reasons, they do the same thing as this woman. The theory behind co-payments has been that this prevents over-utilization of the medical system. In effect, however, those who are prone to demand visiting a doctor for every scratch and ache come normally from well-to-do backgrounds. Co-payments have the effect, therefore, of discouraging poor persons from visiting their doctor when a true medical condition does exist. A study provided by the RAND group covering the Medicare fee-for-service period of 1994-1996 showed that widespread underutilization for services judged to be "necessary" existed for those of low income.[5]

All in all, access to health care within American society is unjustly distributed. As long as health insurance is tied to employment, we believe that we are tacitly supporting a system that either says, "Sickness only visits those fully employed" or "Only the fully employed deserve to access to medical treatment when sick." Both propositions are manifestly false. Those who are suffering due to loss of employment do not deserve to see their children denied access to necessary medical care because of the condition imposed on the family breadwinner. In fact, the health and well-being of the unemployed and the elderly are a precious gift that deserves to be cherished by the whole of society. When anyone among us is diminished, all are diminished.

## Problems Faced in the Quest for Just Distribution of Healthcare

An affordable and universal health care plan involves all the dedicated doctors, nurses, and supporting staff scattered throughout our fifty states. Praise and thanks are due to these individuals who have chosen the profession of being healers within our modern society. In addition, we give thanks to those who are striving to make clean water and air, healthy food, and sufficient shelter available to every American. Health is not an abstract concept. Everyone knows it to be a precious gift. Everyone, therefore, is involved in health care--within their family and neighborhood--even while most of us do not gain our livelihood by treating diseases or discovering cures for diseases.

We recognize that, at the present time, the system of healthcare in the United States cost twice what every other developed nation pays for its universal health care.[6] At first this is shocking. What is even more shocking is that, judging all aspects of health care, the U.S.A. ranks 37th among the nations.[7] Why do Americans pay so much and receive so little from their health care system? At least three reasons are evident to us:

1. In each of the developed nations, a portion of the federal taxes are used to organize and sustain a single-payer system for financing universal healthcare. Our neighbor to the north, for example, finances their healthcare system with 80% federal and 20% provincial funds. The healthcare providers, on the other hand, are privately owned and operated. In each providence, however, fees for procedures and the cost of drugs are negotiated with the providers such that fair remuneration is provided while universal and available access to care remains affordable.

In the United States, the financing of health care has come from a shifting combination of monies from the federal government, from employers, from churches and charitable organizations, and from private individuals (donors and payers). This system, as explained, leaves 43 million uninsured, another 52 million are underinsured, and certain classes of persons enjoying the best healthcare plans available while others are forced to settle with what has been offered to them. Healthcare, consequently, serves to divide us and to create pockets of privilege that are resistant to change. Many Americans, consequently, want to keep things as they are because they want to retain their own privileged access to healthcare and want to insure that HMOs and drug companies remain among the most profitable organizations within the free market system. The 8000 physicians who have called for a National Health Insurance plan, accordingly, argue that only a single payer system will provide a just distribution of healthcare benefits:

> Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, social class and region that compromise the health care of the American people. A single payer program is also key to minimizing the complexity and expense of billing and administration.[8]

2. With the escalation of healthcare costs, insurance companies have provided over eight hundred[9] different solutions for covering procedures and for fair remuneration. The emergence of HMOs in the 60s was first hailed as a solution to the massive escalation of medical costs. In time, however, HMOs have had to back down on their restricted remuneration due to pressure from their clients. Ever since that time, neither free enterprise nor competition has been able to restrain medical costs from growing three or four times faster than the other sectors of the economy.

One major difficulty in reforming our healthcare system is the fact that two hundred different plans for healthcare insurance create enormous bureaucracies whose sole purpose is to revise and interpret changes in their plans. Even among federal employees, there are nearly three hundred distinct insurance plans being funded by the federal government. Meanwhile, every local doctor has to have a billing office that is able to manage the two hundred different forms and the two hundred different set of requirements for coverage. In a 200-bed hospital in the United States, a staff of ten to twelve persons is employed full-time to negotiate the complexity of billing. In a comparable hospital in Canada or Europe, two persons manage the entire billing department. The reason is that Canadians and Europeans have only to understand and interpret one set of requirements and fill in one set of forms.

Researchers at the Harvard Medical School determined that healthcare bureaucracy last year cost the United States $399 billion dollars. This sum would be sufficient, all by itself, to enroll every one of the uninsured Americans in a first-class health insurance plan and to offer complete prescription coverage to every American. As things now stand, Americans need to understand that if private insurance companies are to be retained in our future system of healthcare, then 25-30% of the money spent annually for healthcare will be siphoned off into administrative costs. As things now stand, the Medicare system (a single-payer plan) has only a 3% administrative cost.

The proliferation of private insurance carriers is not only confusing, inefficient, and supportive of bureaucratic waste, it is also forces decision makers in the insurance business to be torn by conflicting guiding principles. On the one hand, the business of insurance companies is to make money and, like any other business, chief executives and stockholders are rewarded on the basis of gross annual profits. The quest for increased profits, unfortunately, runs headlong into the pledge of the company to provide a comprehensive healthcare package to its clients. Fewer people are getting to the doctor of their choice. Pre-existing illnesses are being used to deny coverage. Fine-tuned restrictions are being dictated to physicians as to how they must treat patients if remuneration is to be forthcoming. All in all, the bottom line is that insurance companies increase their profits whenever they are able to restrict or deny medical coverage.

Here is an illustrative case. A member of our parish recently had a tooth that would have required a $600 root canal before it was capped with a $800 crown. According to the dental plan, however, root canals were not covered, and the patient did not have $600 to pay out-of-pocket. The extraction and bridge, however, were completely covered but at a price tag of $2400. When the insurance carrier was contacted and made aware that they would save a $1000 by allowing for the preferred procedure, namely, the root canal and crown, they insisted that **their policies had to be maintained** since they applied to all. The end result was that an unnecessary procedure prejudicial to the long-term health of the patient was performed that needlessly drained away $1000 of healthcare monies. As long as medical decisions made by patients with their caregivers are hedged in by corporate bureaucrats, waste and disregard of the patients health needs will continue to abound.[10]

One can understand from this case why so many physicians are obstructed from doing what is best for the patient because insurance carriers are dictating to them in advance what procedures will be allowed and remunerated. All in all, medical doctors are frequently forced to order diagnostic tests and

use procedures covered by the patient's insurance carrier while, all the time recognizing that, if the patient's health were the prime consideration, they would act otherwise. This conflict of interest is felt by some doctors so acutely that they ultimately leave their profession because they feel that insurance carriers have dictated the course of medicine to such a degree that physicians can no longer act for the well being of their patients.

Federal tax credits of up to $1000 per person will not resolve our healthcare crisis. A hearing of the House Subcommittee on Health on 28 Feb 2002 determined that a family of four would need close to $10,000 to purchase, on the open market, a family plan that an employer would normally be charged only $6000. In addition, the independent plan would refuse to pay benefits for pre-existing conditions--a clause that an employer-purchased plan does not have. All things considered, therefore, federal tax credits to the uninsured would only serve to guarantee a wasteful and inefficient system. It would cost far less and be far more efficient if all the uninsured would be given access to Medicare.

3. Drug companies have been instrumental in developing healing drugs for a wide assortment of medical disorders. Here again, however, the business of creating and marketing drugs gets in the way of healing. A research scientist employed by a well-known drug company reports that the research team had accidentally discovered a drug capable of permanently curing malaria. The marketing department, however, voted not to develop the drug since it would be questionable whether the costs of obtaining FDA approval and of marketing the drug since very few Americans are afflicted with malaria and the peoples in developing countries where malaria is rampant have little or no ability to purchase such a drug. This case indicates how, due to a conflict of interests, the commitment of drug companies to bring healing and well being to the sick runs headlong into their commitment to increased profitability. And, in a system where senior managers and stockholders are rewarded exclusively due to profitability, then the dedication to the sick takes second place.

Drug companies complain that the high cost of drugs is due to their long years of research necessary to discover and test new drugs. In truth, however, drug companies in Europe manage to do the same without expending huge amounts for advertising[11] and for sending out thousands of drug reps who meet with doctors to give them free "trial" samples in the expectation that they will offer them to their patients and develop the habit of prescribing them.[12] The fact that the healthcare system in Canada has negotiated with U.S. health firms to market their drugs north of the border at costs 40 to 300% cheaper than in U.S. pharmacies demonstrates that the drug companies have allowed their ambition for profits to override their service to the common good. Overall, the pharmaceutical industry declared net profits of 18% in the year 2000 while the remainder of the Fortune 500 companies made a medium profit of 5%.

Recent legislation to provide drug coverage for seniors, however, did a disservice to taxpayers when it expressly prohibited Medicare from negotiating with drug companies in order to secure discounts for prescription drugs sold to seniors. The provincial governments of Canada do this, VA hospitals do this, and more than half of state governments[13] have begun to do this. The **AARP Bulletin** notes "there's a groundswell of anger [over inflated U.S. drug prices] that has gone beyond the simmering point."[14] The time has come for legislators to turn back campaign contributions and lobbyist originating from the drug companies and to begin examining with senior citizens how Medicare could wisely negotiate for a reduced cost for drugs sold to seniors.[15] Some would even go so far to say that the federal government should do what every European government does, namely, to allow the F.D.A. to determine and enforce just and equitable guidelines for pricing each time a new drug is approved for sale.[16] In this way, more affordable drugs would be available to all citizens.

## The Gospel and Healthcare

Does our God care about these things? Assuredly! The God whom we have come to know is not just the God of the powerful who exalts in their might. Rather, our God comes to us bent upon readjusting the inequities that the powerful inflict upon the most vulnerable members of our society. It is no surprise to us, therefore, that the teenage Mary, the future mother of Jesus, visits the elderly Elizabeth and rejoices with her in the coming of the Lord as the one who "has brought down the powerful from their thrones, and lifted up the lowly; he has filled the hungry with good things, and sent the rich away empty" (Luke 1:52f). Partly because of the faith of his mother, John the Baptizer later goes on to tell the crowds who come to hear him, "Whoever has two coats must share with anyone who has none; and whoever has food must do likewise" (Luke 3:11). In our own day, surely this applies to healthcare. Whoever has the benefits of a first-class medical plan, therefore, must examine his/her heart to see whether s/he has an obligation to insure that those who are uninsured or underinsured share this same benefit.

Jesus, in parallel fashion, told of the story of "poor man named Lazarus, covered with sores, who longed to satisfy his hunger with what fell from the rich man's table" (Luke 16:20f). Clearly, in this narrative, Jesus takes note of the need for medical attention as well as the need for food. The lack of both and the complicity of the rich man who ignores his brother are what kill Lazarus. For those who honor Jesus and follow his path, therefore, it seems difficult to avoid being concerned about the uninsured, covered with sores, who long to satisfy their medical needs with the blessings that fall from the table of modern medicine.

We prepared this letter during the Christmas season. During this period, we remember Mary who "laid him in a manger, because there was no place for them in the inn" (Luke 2:7). We, as Christians, also await during this period the coming of the Lord and his Kingdom. With our Jewish and Muslim brothers and sisters, we thus lift up our voices in expectation of the righteous king who is to come:

> He shall have pity on the lowly and poor,
> he shall preserve the lives of the needy.
> He shall redeem their lives from oppression and violence,
> and dear shall their blood be in his sight (Ps 72:13f).

If this is the way it will be then, we commit ourselves to live in anticipation of this great day by acting with all persons of good will, no matter what their political/religious orientation, in favor of acting in favor of securing universal health care now. May the God of Justice give us the courage and the grace to be what we need to be and to guide our nation to be what it needs to be to gain God's blessing when he comes.

## Follow Up

The working principles found in the Physicians' Working Group for Single-Payer National Health Insurance provide a summary of what might be expected in our future:

> Four principles shape our vision of reform.
>
> > 1. Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to assure this right. Coverage should not be tied to employment. . . .

2. The right to choose and change one's physician is fundamental to patient autonomy. Patients should be free to seek care from any licensed health care professional.
3. Pursuit of corporate profit and personal fortune have no place in caregiving and they create enormous waste. The U.S. already spends enough to provide comprehensive health care to all Americans with no increase in total costs. However, the vast health care resources now squandered on bureaucracy (mostly due to efforts to divert costs to other payers or onto patients themselves), profits, marketing, and useless or even harmful medical interventions must be shifted to needed care.
4. In a democracy, the public should set overall health policies. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.

We envision a national health insurance program (NHI) that builds upon the strengths of the current Medicare system. Coverage would be extended to all age groups, and expanded to include prescription medications and long term care.[17]

Members of Trinity Episcopal Church who have considered these things and who find themselves in substantial agreement have fixed their signatures below. In cases where email addresses are given, the members are open to discussing this letter with other parishes or with persons considering the endorsement of this letter. In addition, this letter will be posted on a website at www.didache.info where everyone is invited to leave comments and to add their signatures. On 01 May 2004, this letter and all its signatures will be given to our local, state, and national officials. Again, on 01 Sept 2004, this will be done again. This action will be repeated as the circle of supporters widens until such time that every American has access to an efficient and affordable health care system. Meanwhile, anyone and everyone is encouraged to use this letter by way of promoting open discussion and the movement toward a national consensus on this urgent issues. Revised by AR, 24 Mar 04.

## Endnotes

1... "From 1991 to 2001, the number of seniors filing for bankruptcy increased by 244%, making them the fastest-growing segment of the population. Harvard University's Consumer Bankruptcy Project found that nearly half of the elderly people who end up in bankruptcy say that they filed because of a medical reason" (http://www.seniorjournal.com/NEWS/Politics/3-07-29houses.htm).

2.. At the same time, as long as health care is tied to employment, many would-be entrepreneurs never launch their new business because they cannot risk losing health insurance.

3... Hearing before the U.S. Congress Subcommittee on Health, 28 Feb 2002, p. 42.

4.. Bob Lebow, M.D., **Health Care Meltdown** (Boise, ID: JRI Press, 2002) 62.

5... A.M. Asch, et. al., "Measuring underuse of necessary care among elderly Medicare beneficiaries using inpatient and outpatient claims," **Journal of the American Medical Association** 284 (2000) 2325-33.

6.. In 1998, the average per capita cost for healthcare in the U.S. was $4200. Switzerland and Germany, the two countries with the next most expensive system, paid $2800 and $2400 respectively. In Canada, the costs were $2300 per capita.

7.. Data from World Health Organization, 2000. "The world health care report - health systems: improving performance,"
(Geneva, World Health Organization).

8.. "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance" http://www.physicianspproposal.org/embargoed/angell.html

9. A study of 2277 people in Seattle discovered that, among those insured, there were 755 different health insurance policies and 189 different health insurance plans (Donal Light, "Health Care for All," **Commonweal** (2/22/02).

10. Dr. Bob LeBow notes that those who have the "gold card" insurance plans routinely ask for MRIs for back pain, prostrate biopsies, and echocardiograms precisely because their insurance pays for it. Meanwhile, of course, those who urgently need such sophisticated tests often cannot afford them or are placed at the back of the waiting line (**Health Care Meltdown** [Boise, JRI Press, 2002] 68-73). The present reimbursement system rewards the inefficient, said Dr Molly Joel Coye, president of the Health Technology Center, San Francisco. "When hospitals and doctors improve quality of care for their patients they often lose money," Dr Coye said. She cited one study on 13000 diabetic patients that identified changes in the management of patients that could have saved some $10m. But if they had been introduced the improvement in patients' health would have resulted in fewer visits by patients, which in turn would mean a decline in reimbursement payments. http://www.findarticles.com/cf_dls/m0999/7286_322/72606660/p1/article.jhtml

11... According to industrial estimates, drug companies spent $15.7 billion dollars on promotion in 2000. In this same year, A. Merck & Co. spent $161 million on advertising for Vioxx. That is more than PepsiCo spent advertising Pepsi ($125 million) and more than Anheuser-Busch spent advertising Budweiser ($146 million) (**NIHCM**).

12... From the notes distributed by Dr. Hess, sixty million "details" were made by 83,000 drug reps (representatives) in the year 2000. Astra-Zeneca added 1,300 reps solely to promote Nexium (**Scott-Levin Consulting**).

13... "To date, almost half of all states have enacted laws to reduce the costs of prescription drugs or are now trying to move legislation to do so" (**AARP Bulletin** 45/1 [Feb 2004] 7).

14... **AARP Bulletin** 44/10 (Nov 2003) 4.

15... Angry letters from seniors can be found in **AARP Bulletin** 45/1 (Feb 2004) 14f.

16.. According to the Physicians' Working Group for Single-Payer National Health Insurance:

> NHI will pay for all medically necessary prescription drugs and medical supplies, based on a national formulary. An expert panel would establish and regularly update the formulary. The NHI would negotiate drug and equipment prices with manufacturers, based on their costs (excluding marketing or lobbying). Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest cost medication, with exceptions available in case of medical necessity. Suppliers would bill the NHI directly (for the negotiated wholesale price plus a reasonable dispensing fee) for any item in the formulary that is prescribed by a licensed practitioner.

17.. "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance" http://www.physicianspproposal.org/embargoed/angell.html Some would argue that a National Health Insurance program should cover all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long term care, mental health services, dentistry, eye care, chiropractic, and substance abuse treatment.