

**Resolution On
Christian
Responsibility
And A
National
Medical Plan**

A Report Approved By The 203rd General Assembly (1991)

Presbyterian Church (U.S.A.)



**RESOLUTION ON
CHRISTIAN RESPONSIBILITY
AND A
NATIONAL MEDICAL PLAN**

**A RESOLUTION
ADOPTED BY THE 203RD GENERAL ASSEMBLY (1991)
PRESBYTERIAN CHURCH (U.S.A.)**

**PUBLISHED BY
THE OFFICE OF THE GENERAL ASSEMBLY
100 WITHERSPOON STREET
LOUISVILLE, KENTUCKY 40202-1396**

Copyright © 1991

The Office of the General Assembly
Presbyterian Church (U.S.A.)

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronically, mechanically, photocopying, recording, or otherwise (brief quotations used in magazine or newspaper reviews excepted), without the prior permission of the publisher.

The sessions, presbyteries, and synods of the Presbyterian Church (U.S.A.) may use sections of this publication without receiving prior written permission of the publisher.

Printed in the United States of America

Additional copies available at \$1.50 each from Distribution Management Services (DMS), 100 Witherspoon Street, Louisville, KY 40202-1396, or by calling 1-800-524-2612 outside of Louisville; 502-569-5000 ext. 2503 in Louisville.

Please specify DMS order #OGA-91-021.

September 1991

To Pastors of Churches and Clerks of Sessions of Vacant Pulpits, and Stated Clerks and Executives of Presbyteries and Synods

Dear Friends:

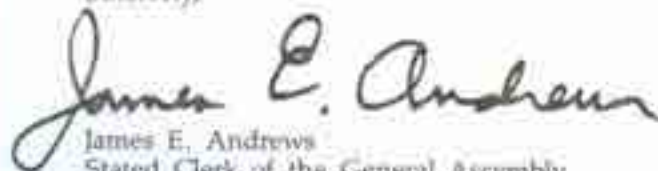
The 203rd General Assembly (1991) expressed its concern for universal access to health care by adopting a resolution on "Christian Responsibility and a National Health Plan." As directed by the assembly, this document, with study guide attached, is being distributed to all clerks of session and to all ministers of Word and Sacrament in each presbytery.

The resolution outlines thirteen elements of an equitable medical plan based upon the church's biblical and theological mandate. These thirteen elements become, for the Presbyterian Church (U.S.A.), the criteria for evaluating legislative and administrative actions.

I believe this document is a contribution to the national debate on access to health care, and I believe it will guide our thinking on health care throughout the nineties.

Additional copies of this report and study guide may be ordered as indicated on the copyright page of this publication.

Sincerely,



James E. Andrews
Stated Clerk of the General Assembly

CONTENTS

Resolution	1
Summary	2
Recommendations	4
Background	6
The Mandate	6
Trapped by Inaction	7
The Church's Social Policy	8
Toward a Theological View	12
Health, Health Care, and Justice from a Christian Perspective	13
Health, Health Care, and Justice in American Society	20
Toward a Strategy for Reformation: The Elements and Principles of a National Medical Plan	23
Endnotes	35
Study Guide	39
Appendix A	48

RESOLUTION ON CHRISTIAN RESPONSIBILITY AND A NATIONAL MEDICAL PLAN

The 203rd General Assembly (1991) decries our nation's failure to establish an equitable, efficient, and universally accessible medical plan. It asks the nation's legislative leadership, with help from religious, health care, insurance, and other organizations or industries, to break the impasse for the purpose of establishing a National Medical Plan. It returns to the roots of healing found in our faith and speaks forthrightly for health care services guided by theological vision. It calls upon the Presbyterian family to step into the fray, advocating access to health care for all.

*Over 31 million
Americans do
not have health
insurance.*

The 203rd General Assembly acknowledges that

- over 31 million Americans do not have health insurance;¹
- over 65 million Americans are currently underinsured and exposed to large out-of-pocket expenses;²
- over 50 percent of the work stoppages of 1989 were health care related;³
- over 14 million persons do not seek the care they need because they are unable to pay for it;⁴
- many insurance programs do not cover prior conditions and, thus, limit the economic freedom (flexibility) of the medically at-risk population;⁵
- health care spending is the leading cause of personal bankruptcies in the United States;⁶

- * almost 12 percent of our Gross National Product, the highest percentage among the world's industrial market economies, is expended on health care;⁸
- * 89 percent of the American populace believes that the time has arrived to reform the United States health care system.⁹

A description of our current health care crisis could fill many pages of text.¹⁰ It need not. The 203rd General Assembly (1991) simply recognizes that most Americans desire an equitable and accessible health care system. The current system is neither; it fails the American dream of compassion and justice. Corporate society is squeezed by its high costs. Morally sensitive individuals are scandalized by its inequity. A growing number of individuals are suffering and dying because of lack of access to health care. Increasing numbers of people are becoming impoverished by health care costs. Reformation is required.

SUMMARY

The resolution's background begins by describing the impact of the health care crisis on one individual. She is trapped, unable to respond to God's call to work in a new setting. The record of health care in the waning years of the twentieth century is the story of entrapment and abandonment. Too many of us have no access to health care. Many more of us are facing reduced benefits and the threat of economic hardship and even bankruptcy. Our children and parents are at risk. The pattern is distinguished by diminished access and dwindling benefits.

In such a grave situation, Presbyterians at all levels are called upon to act in whatever way they are best suited to bring about a comprehensive National Medical Plan.

The Committee on Social Witness Policy (CSWP) submitted the following report on "Christian Responsibility and a National Medical Plan" to the 203rd General Assembly (1991) of the Presbyterian Church (U.S.A.) and urged the assembly:

- * to adopt the report and its recommendations;
- * to approve the report for churchwide use; and
- * to direct the Office of the General Assembly to print the entire report on "Christian Responsibility and a National Health Plan" and distribute it in a timely manner to
 - all ministers and clerks of session of the Presbyterian Church (U.S.A.);
 - leaders of other communions, including ecumenical partners;
 - members of the United States Congress;
 - appropriate persons in the executive branch of the federal government;
 - governors of all states; and
 - selected leaders of organizations working for universal access to health care in the United States.

It is the sincere wish of the committee that the church heed this call and apply its influence, collective and individual, upon both federal and state governments to achieve these ends. The entire report is recommended for reading by the leadership and members of the church.

Presbyterians at all levels are called upon to act in whatever way they are best suited to bring about a comprehensive National Medical Plan.

A growing number of individuals are suffering and dying because of lack of access to health care.

RECOMMENDATIONS

The 203rd General Assembly (1991):

- a. Calls upon the president of the United States and his administration to provide moral and political leadership so that an equitable, efficient, and universally accessible health plan, which includes a National Medical Plan defined by the elements and principles noted in the background, will be established.
- b. Calls upon Presbyterians who are active in party politics to seek candidates for office, especially for their party's presidential nomination, who will place high priority on the establishment of an equitable, efficient, and universally accessible health plan, which includes a National Medical Plan.
- c. Calls on the nation's legislative leadership to establish such a National Medical Plan. Until a plan is instituted, we call upon the federal and state governments to
 - (1) Protect uninsured persons, especially those with low or fixed incomes, from erosion of health care benefits or an increase in cost of health care benefits;
 - (2) expand medicare and medicaid benefits; and
 - (3) engage in tort reform so that malpractice costs might be reduced.
- d. Directs the Stated Clerk to distribute this document to the president of the United States, the Congress, and the governors of each state.

- e. Directs the Stated Clerk to distribute this document to the ecumenical and interfaith partners of the Presbyterian Church (U.S.A.).
- f. Directs the Stated Clerk to distribute this document, with a study guide attached, to all clerks of session and to all ministers of Word and Sacrament in each presbytery.
- g. Directs the Social Justice and Peacemaking Ministry Unit to seek means of cooperative advocacy with the church's middle governing bodies and interfaith partners so that a campaign for universal access might be initiated.
- h. Directs the Education and Congregational Nurture Ministry Unit to work with the Social Justice and Peacemaking Ministry Unit in its Peacemaking Program and Presbyterian Health Network; the Stewardship and Communication Development Ministry Unit in its Stewardship of Life program; and the Women's Ministry Unit in the development of education and advocacy materials on universal access to health care.
- i. Authorizes the Board of Pensions to develop appropriate health promotion and education programs that include information about universal access to health care and this resolution.
- j. Urges church members and committees and the presbyteries to renew ministries of advocacy so that an equitable, efficient, and universally accessible health plan, which includes a National Medical Plan, might be adopted by Congress and the state legislatures.

*The 203rd
General
Assembly
(1991)
authorizes the
Board of Pen-
sions to develop
appropriate
health
promotion and
education
programs that
include
information
about universal
access to health
care and this
resolution.*

- k. Supports churches and middle governing bodies that establish interim health services, including medical clinics, for those lacking access to health care.
- l. Encourages all members of the Presbyterian Church (U.S.A.) to engage in advocacy for universal access to health as a normative part of their devotional life and stewardship commitment.
- m. Requests a report, with appropriate recommendations, from the Committee on Social Witness Policy to the 207th General Assembly (1995) based on a review of denominational program and policy, the proposals included in this resolution and in *Life Abundant*, and the political context existent when that report was created.

The 203rd General Assembly (1991) encourages all members of the Presbyterian Church (U.S.A.) to engage in advocacy for universal access to health as a normative part of their devotional life and stewardship commitment.

BACKGROUND

The Mandate

The 202nd General Assembly (1990) received from the Committee on Social Witness Policy an emerging issue paper, "Universal Access to Health Care."¹¹ It approved the paper for study and comment by the church. The Stated Clerk printed and distributed the document in fall 1990. Responses were received from across the church.

The 202nd General Assembly (1990) requested the completion of an "informed" report on universal access for the 203rd General Assembly (1991). The above study process helped define CSWP's understanding of congregational and presbytery concerns. It also drew upon a rich tradition of policy, of which the latest example is *Life Abundant: Values, Choices and Health Care*, a policy statement adopted by the 200th General Assembly (1988).¹²

The following report was written in response to the request of the 202nd General Assembly (1990). It is a prayer written and offered for those trapped in a health system that does not provide universal access.

Trapped by Inaction

Light drained from her room. The sun was setting in early winter. She sat at her desk unable to move.

In her hand was a letter. It confirmed her appointment to a senior administrative post in a national nonprofit corporation. It was a prayer answered, a job prized. Or was it?

The new call would remove her from the rolls of the Board of Pensions' Health Benefits Plan. The new plan contained an exclusion clause. No prior conditions would be insured. Not her prior condition. Not anyone else's prior condition.

In a file in the desk was a raft of bills from the past year. They surpassed \$8,000. If she changed jobs, they would not be covered. Her prior condition could cost her greatly, maybe more than the raise promised by the new job. And, if her back deteriorated, the financial gains for which she had worked, all her savings and her house, could be wiped out.

Should she take the new job? Would it risk her financial health? At the peak of her professional ability, should she remain trapped in her current call?

The health care crisis is no longer something happening to someone else. It affects you and me; low, middle, or high income; majority or minority; young or old. It determines our personnel policies, dogs our career paths, fails our families, and drives our economic decisions. Our

The health care crisis is no longer something happening to someone else.

nation is trapped by its inability to provide equitable, efficient, and universal access to health care.

The Church's Social Policy

The 203rd General Assembly (1991) takes its place as the latest in a long history of General Assemblies concerned with health and healing. Its analysis and recommendations are not novel; however, they are no less urgent.

The policies, reports, and resolutions of the past fifty years were created in various contexts. Patterns have emerged: traditional, transitional, and contemporary. Each tells a story of the Presbyterian church's concern for access to quality health care.

As early as 1946, the 158th General Assembly defined universal access to health care and called for reform of sources of funding.

The Christian should manifest active concern in the failure of society to marshal its full resources for health for all people. In countless cases, health is denied because of the lack of funds by the individual in need of medical services and the lack of medical resources. In the name of the Great Physician, we favor federal legislation that will join appropriate civic, professional and other bodies, in co-operation with government, in providing the means for adequate medical care whenever needed."

Ten years later, the 168th General Assembly of the Presbyterian Church in the U.S.A. met in Philadelphia and turned its attention to the relationship of biomedicine and the religious community. It appointed a special committee that labored to define the church's contribution to

healing. It benefited from the clinical pastoral care movement's growing influence. At the 172nd General Assembly (1960), the report, "The Relationship of Christian Faith to Health," was received.

The special committee's report observed that

... Pastors and physicians did not always work in ways apparently so different as they do today. At one time in history, medicine was closely linked with religion. This was followed by a period in which medicine became almost completely secularized.¹⁴

The time had come, the committee thought, for the church "to explore the relation of the Christian faith to health in a way that takes account of both modern science and historic Christian experience."¹⁵ A new day of cooperation was dawning. The church was renewing its participation in the healing professions and restating the values it brought to the health care system.

Taken together, the traditional policies, approved in 1946 and 1960, articulated a concern for access and the values that sustained access. They recall the church's role as provider of health care. Members of the biomedical community were encouraged to discover their vocation. The religious community was asked to improve its healing skills, specifically those skills with explicit religious content.

The societal context, however, changed. The Presbyterian community was challenged in new ways. During the 1950s, an expanding proportion of the nation's population had gained access to health care through private health insurance coverage. Many unemployed, underemployed, young, and retired individuals, however, failed to

In countless cases, health is denied because of the lack of funds by the individual in need of medical services and the lack of medical resources.

At one time in history, medicine was closely linked with religion.

gain adequate protection. Coverage varied in patterns that revealed race, gender, and class distinctions. The church could not remain silent. It entered a transitional period.

In 1961, the 173rd General Assembly of the United Presbyterian Church (U.S.A.) called for

... extended prepayment insurance benefits under private auspices, expanded Social Security legislation, federal assistance to the states for more adequate care for older persons in need, and improved privately sponsored facilities and services. . . .¹⁸

Two years later, the aging were again a concern. This time the church was to "conduct studies and consultations which will keep this unsolved problem before the people. . . ." A 1968 General Assembly noted the needs of a healthy urban environment.¹⁹ In 1969, the 181st General Assembly recognized that access to care was limited by the "organization and delivery of health services."²⁰ In a new social context, the church's voice gained prophetic clarity.

During the 1960s and 1970s, public health insurance coverage was expanded by legislative action. The church, during this transitional period, became concerned with entitlements. Early 1960s policy calls for new groups to be covered by public insurance. Later assembly actions call for expansion of entitlements that assist groups not yet receiving adequate coverage.

As the 1970s gave way to the Reagan era, public policy was influenced by inflation's threat to benefits. It became clear that existing patterns of organization, financing, and reimbursement were inadequate. The implications, which were played out in higher costs, compromised quality, and

limited access, were disquieting. Thus, the contemporary era can be described by

- (1) An explosion of biomedical knowledge and medical technology that has offered the promise of care and cure—but often at substantially increased costs;
- (2) A lack of standards for necessary and appropriate care, which has made it difficult to define limits of care in the face of growing demand;
- (3) A cost-based, retrospective reimbursement system that has encouraged the unlimited use of health care resources;
- (4) A real and well-founded fear by many health care providers of malpractice suits, which has distorted the practice of medicine by health professionals and hindered good relationships between provider and patient;
- (5) Rather than pooling and spreading risk within the private health insurance system, insurers have avoided risk, decreased coverage, and increased profits;
- (6) The failure of political will (based on values that emphasize provider autonomy and consumer freedom of choice) and of economic will (based on values that emphasize profit and earned entitlement to health care) has frustrated attempts by the public and private sectors to control rising health care costs.

The failure of political will and of economic will has frustrated attempts by the public and private sectors to control rising health care costs.

In response, General Assemblies have met, prayed, and spoken. Recent assemblies have

- (1) confessed the limits of medical technology and the finitude of human experience,^{20,21}

- (2) called for the creation of standards of care;²⁷
- (3) discussed (but not set policy concerning) development of a prospective reimbursement system;²⁸
- (4) sought the reform of the tort system for the purpose of limiting the inappropriate fear of malpractice liability;²⁹
- (5) encouraged the full coverage of all individuals for purpose of access to appropriate health care, while calling upon the private health insurance industry to either abandon its work or participate in the reform of the health care system;³⁰ and
- (6) worked for the renewal of theological, political, and economic values that will inform a full public debate and usher in reform.³¹

Each assembly has spoken in the context of its day. The 203rd General Assembly (1991) is no different. It recognizes the pressing need to provide increased access to health care. It sees that the crisis of the 1990s requires a structural response. It understands the hunger for theological and ethical reflection that can define a Christian response to the crisis of today. Thus, this document, at this time, is a statement offered with prayer that it might inform the debate raging over our nation's health care system. It is not our community's final statement. New contexts will call forth renewed reports and resolutions.

Toward a Theological View

A nation, gathered from peoples bearing multiple faiths and varied hues of ethnicity, shapes its public debate using resources drawn from both public policy and theological communities. The debate over health care is no exception. It is a

crisis of both social organization and theological integrity.

As a society we have failed to decide on an appropriate place in our common lives for health and health care; therefore, we have not found the moral courage to place appropriate limits on our heedless pursuit of health and health resources. Our society has failed to affirm both the uniqueness of individuals and their place in community. Accordingly, we continue to vacillate between extremes of universal, unlimited entitlements and inequitable limits on costs.

The church is caught in society's vacillation. Often it is called upon to legitimize cultural values, supporting the ideal of unlimited individual entitlements without communal responsibility. Because the ideal is unsustainable, we become vulnerable to strategies that cut costs inequitably. Swinging to the other extreme, the church is called upon to legitimize the exclusion of some individuals from access to necessary and appropriate care. Neither of these can the church countenance; every individual is precious in God's sight and deserves sustainable access to health care. From its biblical and theological resources, the church has the means to challenge the prevailing values and to offer an alternative vision of its own.

Health, Health Care, and Justice from a Christian Perspective

The collected statements of prior General Assemblies, including *Life Abundant*, describe affirmations about health and medical care. The reader is referred to these documents.³² However, the more specific question of access to health care in light of current cost containment initiatives

Our society has failed to affirm both the uniqueness of individuals and their place in community.

Recent General Assemblies have encouraged the full coverage of all individuals for purpose of access to appropriate health care.

requires further attention. The convictions of our biblical and Reformed tradition sharply differ from those of standard secular positions just mentioned.

Caring

Health care and medical services are, above all, the way a community ministers to ill persons in their finiteness and vulnerability. Caring for the vulnerable has been at the center of Western medicine from the earliest times. It justified the high calling of the practice of medicine even when cures for most afflictions were unavailable.

For Christians, caring bears witness to the fact that God is with us and never abandons us. In all our human frailty and vulnerability—a frailty and vulnerability made especially acute during times of illness—God remains with us.

Caring is imperative even when curing is not possible. To care when hope of cure or recovery has passed testifies to the value of the person, not only the healthy person, before God. It says that life has value beyond health. Technology, in forms of skill and equipment, does not in and of itself constitute care, but care may be and often is expressed through technology.

When we exclude persons from access to health care, we render bankrupt our witness to the God who never abandons anyone in the margin. When we cynically maintain that caring can still be expressed outside of a medical service system, we deny the vocation of those set aside to express care and the appropriate role of the vulnerable. Whether Western biomedicine is as effective as our nation often assumes is open to question, but to exclude some from this powerful way in which

our society expresses solidarity with the vulnerable and testifies to the care of God is unacceptable and unconscionable.

Doing Justice

In the image of the body of Christ, Paul proclaims the distinctive Christian contribution to an understanding of justice. Each member is unique, irreplaceable, and of equal value, yet each exists and is fulfilled only in relation to all the others.

Three affirmations sum up the biblical view of justice as seen from this theological perspective:

- Each person is unique and irreplaceable; the community is impoverished by the exclusion of any person from the community or the oppression of any individual within the community.
- Each person exists as a member of the community; the gifts, talents, accomplishments, and even the existence of each person are a blessing for others and for the community as a whole.
- Christian justice has special regard for the oppressed and afflicted of all times and places, namely those whose personhood or whose opportunity to be blessed by or to be a blessing to others is denied or suppressed.

This understanding of justice stands in sharp contrast to the two views of justice in our society that dominate discussions of who is to get how much and what kind of medical care. The first supports those who, like the eye and the hand in the Pauline passage, say to the rest of the body, "I have no need of you." They ignore or deny that individuals exist also for the sake of community.

Health care and medical services are, above all, the way a community ministers to ill persons in their finiteness and vulnerability.

Those who distribute health care or other resources solely on the basis of narrow revenue or cost calculations, on the other hand, seem to force those who lose out in such calculations to conclude that, "because I am not a hand or an eye, I do not belong to the body."

People of biblical faith are forbidden from making value judgments about whether hands, feet, eyes, or ears are more valuable to the body. Put differently, we never know who among us makes the greater contribution to the human community. Christians believe that, in God's sight, the widow's mite may count far more than the numerically larger contributions of others. The laborers who began work an hour before sundown may be equal in value to the laborers who began at dawn.

As the church seeks to witness to Christ in the public arena, Paul's image of the body can be imaginatively applied to the broader society. The body symbolizes the character of community that God intends for the entire human family. A Christian view of justice challenges a pluralistic and secular society to affirm the interdependence of all members of the community. Universal access to health care, among current options, is the only one that is connected with this understanding of justice.

Preventing, Curing, and Building Community

The 172nd General Assembly (1960) wrote

The Church's ministry to the sick is not limited to those who are suffering in some obvious way from physical or mental illness. It is both preventive and curative. There can be no

doubt that the conversion and the nurture of [people] to faith in Jesus Christ make contributions of utmost significance for their welfare here and now as well as for their ultimate salvation.²⁸

Today we reaffirm that health care not only expresses care but also prevents disease, restores health, and enhances well-being. Just as caring is not an end in itself but witnesses to deeper and more pervasive caring, so preventing and curing are not their own ends but serve to fulfill human beings in their participation in the community. Hence health care is not a right or entitlement of individuals as such to pursue personal perfection.

But neither is it simply the prerogative of the community itself, to be distributed on the basis of some analysis of costs and benefits for the society as a whole. Our convictions about justice prevent us from attempting to determine the worth of an individual or his or her benefit to community. All are created. All may be called. All sin and fall short of the glory of God.

By preventing, restoring, and enhancing, health care confirms to each person his or her irreplaceability. She is important for the well-being of others. He is an integral part of the whole. When persons are excluded from health care, they are in effect being told that their uniqueness is not valued and their contributions to the well-being of the larger community are less important. For all these reasons, we reject any attempt to exclude people from health care or to limit their access on the basis of race, sex, income, age, social or ethnic group, demography, disability, existing condition, and so forth.

Today we reaffirm that health care not only expresses care but also prevents disease, restores health, and enhances well-being.

Stewardship

God created a finite world, not an infinite one. Stewardship is the exercise of responsibility in our finitude.

There is much talk of limitation, cutting back, and rationing among those involved in health-care policy. All of these terms connote scaling back from an implicit, ideal state of affairs in which literally everyone has access to literally everything. Given this assumption of health and health care as ends in themselves, the concepts of limitation, cutting back, and rationing can only appear as negative signs of decline from the ideal. No wonder politicians and policymakers hesitate to invoke these words. No wonder our society lacks the courage to restrain itself.

The church does not speak the language of limitation or cutting back. It speaks of caring, preventing, curing, restoring excellence, and reverencing life. Within this framework it also speaks of stewardship. If society has no sense of purpose for health care, it exercises no stewardship. It is forced to limit, cut back, and ration health care in an often irrational, unjust way.

The purposes, as we see them, are the purposes of caring, preventing, curing, and restorative activities just mentioned. Medical interventions should be judged by their efficacy in relieving pain, increasing comfort, and by other appropriate indicators of caring on the one hand, and by their efficacy in preventing disease, promoting health, restoring functioning, and preventing or slowing the deterioration of functioning on the other hand.

Our society often presses health care into the service of an expensive and wasteful denial of human finitude. But we affirm that interventions

that occur when cure is impossible and that do not serve purposes of caring are unnecessary and wasteful. Our society also draws the medical community into its failure to accept that God has taken life or never given it in the first place. But we affirm that research and treatment whose chief and direct purpose is to extend biological life at either end of the life cycle or to extend the frontiers of medicine are likewise unnecessary and wasteful.

In general, priority should be given to those procedures and interventions that communicate care and that realistically improve one's capacity to participate meaningfully in contributing to the well-being of others and of the whole community. But since we remember that the justice of God always shows special concern for the afflicted and oppressed, justice demands that our health-care system give priority to those whose afflictions alienate them from society or stigmatize them. These are often the very people who would lose out in a benefit analysis or cost analysis of justice. Obviously, their claims must be weighed against those of others, and what counts as stigma or alienation varies with cultural setting. However, their medical needs should be given priority over treatments that are expensive and benefit mostly a few who are not socially, economically, or medically at risk.

Community

All members of the community participate in solidarity with each other. Illness is not the burden of the ill alone, nor is caring, which is the expression of divine care, the calling of health professionals alone. It is appropriate that the costs of health care be shared by the whole population.

Illness is not the burden of the ill alone, nor is caring, which is the expression of divine care, the calling of health professionals alone.

If society has no sense of purpose for health care, it exercises no stewardship.

The individual is not the only one who benefits from prevention and cure. The individual does benefit, hence he or she should pay something for his or her treatment. The economic sector of society also benefits from a healthy work force and can therefore be expected to pay. However, the economic sector should not pay everything; work is not simply for the well-being of businesses and corporations. Health care does not serve only the ends of productivity. Realization of the rich and diverse goods of the community as a whole, including but not limited to "productive" work, is enhanced by the health of persons. This includes those vast spheres of activity that enhance our families, communities, and culture. Hence the society as a whole, which benefits from these activities, should be expected to pay for health care as well, in the form of taxes. Of course, at all levels, ability to pay should be the criterion.

Because communities thrive on diversity, health-care planning should take full account of the health needs and expectations that enable different peoples and groups to thrive. Community does not mean uniformity. Peoples and groups, and also individual patients and providers, should be allowed the maximum range of choices, so long as they are compatible with the purposes of health care described above.

Health, Health Care, and Justice in American Society

Our political economy has few resources for dealing with the limitations of medicine itself or of our ability to finance health care. We have no criteria for determining what forms of research and treatment are worthy or unworthy except the criterion of effectiveness, no language for facing limits except the language of decline, no moral

standards for distributing benefits and burdens except the standards of individual rights and benefit or cost analysis. In this limited moral vision, the three following views of health and justice go largely unchallenged.

- (1) For some people, perfection of health is an end in itself. Anything that contributes to physical and emotional well-being is justifiable. Medical care is valued as a presumably effective means of attaining the end of perfect health.

This is a form of religious perfectionism; it is no coincidence that many perfectionist religious movements in our nation have been perfectionists about health as well. This is also a form of narcissism that never asks whether and how the individual's health may benefit others. There is little or no incentive to set priorities or face limits. Those who accept this view of health either hold the impossible ideal that all persons will have access to all that enhances health, or, when its impossibility becomes obvious, they hold the cynical view that the pursuit of health is like the pursuit of any other desirable state: accessible to those who can afford it, with minimal provisions for those who cannot.

- (2) For some people, not health but medical care is the focus. The drive for new technology becomes a fetish. The visible manifestations of health care are endowed with unrealistic significance, desired as ends in themselves whether or not they actually improve health.

The visible manifestations of health care are endowed with unrealistic significance, desired as ends in themselves whether or not they actually improve health.

Our political economy has few resources for dealing with the limitations of medicine itself or of our ability to finance health care.

When medical care becomes a fetish there is little incentive to ask about the appropriateness of either the development or use of technology. Life support systems whirl on when life has ceased, neonatal technology lowers the threshold of viability for no apparent purpose, diagnostic novelties become routine procedures. It becomes impossible for professional and patient alike to set limits on research or the use of medical technology. Again, the *de jure* standard of justice is access by everyone to everything, while *de facto* justice follows the rule of ability to pay and a "decent minimum" for everyone else.

- (3) For some people, health and medical care is an effective means toward a productive society. This group is gaining a voice in our society as the economic impossibility of maintaining the other two views becomes obvious. Advocates of this view are more likely to set priorities for research and treatment. They argue that health and health care are not absolute goods. But they are also likely to make access to particular medical services dependent on potential or actual benefit to society. Consideration of other factors and objective criteria for assessing benefits may be missing.

This particular view assumes that human beings live for society alone. It usually assumes a society as defined by and for the social and economical elite, whose values and prejudices determine the definitions of "benefit" and "cost."

Toward a Strategy for Reformation: The Elements and Principles of a National Medical Plan

Health care confesses human vulnerability while equipping persons for participation in community. This is an invitation to share in God's creative activity. These convictions set us far apart from those who argue that health care is like any other commodity and ought to be distributed like any other reward for achievement, though with provisions for a basic "decent minimum" for others. Since opposition to our viewpoint is so pervasive, it is wise for the Christian community to translate its theological presuppositions into a practical strategy for reforming the health care system.

The 203rd General Assembly (1991) describes its strategy in the following paragraphs. It should be pointed out that what is being described is a National Medical Plan. This plan focuses principally on the issues of organization, financing, and delivery of medical care services. A national health plan would be more comprehensive. In addition to a National Medical Plan, it would include other non-medical measures such as sanitation, nutrition, occupational health, consumer education, control of environmental pollution, and the arts of religious healing and restoration, all of which contribute to the prevention of disease. Likewise, the healing professions include services provided outside those defined in a National Medical Plan.

The assembly recognizes that the public debate will be shaped by some values not consistent with the Christian faith. It does, however, state that the unique role of the church is not diminished by the

Health care confesses human vulnerability while equipping persons for participation in community.

diversity of debate. The Presbyterian church has an obligation to speak from the ethical and theological values of Christ's community. Many of these values are articulated in the policies of this and prior General Assemblies. These policies include, but are not limited to, *Life Abundant* and this statement. These policies and their underlying values prompt the church to describe the elements and principles of a National Medical Plan.

Values

Definition: Values refer to the fundamental principles that underlie the National Medical Plan.

Basic Principles: The basic principles or values that should guide the development and implementation of a National Medical Plan are

- caring,
- doing justice,
- preventing,
- curing,
- stewardship, and
- building community.

Eligibility

Definition: Eligibility refers to the criteria used to determine the population to be covered by a National Medical Plan.

Basic Principles:

- A National Medical Plan should encompass the entire population residing in the United States.
- Coverage of the population should be mandatory and not voluntary.

Benefits

Definition: Benefits refer to the medical services made available to the population under the terms of a National Medical Plan.

Basic Principles:

- The services to be offered as part of a National Medical Plan should only be those that are determined to be necessary and appropriate for the timely and effective prevention and treatment of conditions affecting the health and well being of individuals and communities, rehabilitation from such conditions, the general promotion of good health, and such supervision and assistance with the activities of daily living as may be necessary to provide humane care for individuals suffering from chronic and/or terminal illness.
- Because insufficient resources are available to provide all benefits, preference in the selection of benefits to be included in a National Medical Plan should be given to those services that contribute to communal as opposed to individual interests.
- The benefits selected for inclusion in a National Medical Plan should be available without regard to geographic or political jurisdiction (that is, receipt of the services should not be contingent upon residence in a particular geographic or political jurisdiction ["portability of benefits"]).
- The benefits provided should encourage the prevention of illness and the use of the most cost-effective services.

The benefits provided should encourage the prevention of illness and the use of the most cost-effective services.

The Presbyterian church has an obligation to speak from the ethical and theological values of Christ's community.

Financing

Definition: The financing of a National Medical Plan refers to the sources of funds used to operate the plan and to fund the cost of the benefits to be provided to the covered population. At present, financing for health care comes from several sources:

- insurance premiums paid by individuals;
- insurance premiums paid by employers;
- income, payroll, and special taxes paid by individuals and corporations at the federal, state, and local levels;
- out-of-pocket payments to providers by individuals; and
- charitable contributions.

Basic Principles:

- Equity: All individuals and organizations (i.e. employers) who benefit from the plan (such as having a healthy workforce) should contribute to the financing of the plan based on the principle of ability to pay.
- Justice: Since society has an interest in the health of its people, those individuals and organizations who can pay should help to finance the care for those individuals and families who cannot pay.
- Efficiency: The least costly method for collecting the necessary funds to finance the health system should be used. We favor a national-level, progressive income tax for individuals and corporations as the most efficient system available at present.

We favor a national-level, progressive income tax for individuals and corporations as the most efficient system available at present.

Reimbursement

Definition: Reimbursement refers to the methods that are used to pay providers for the services they render. Historically, reimbursement for medical services has been retrospective (payments are made after the service is rendered) and charge-based (the providers receive whatever charge they establish for the rendered service)

Basic Principles:

- A maximum annual or biennial limit should be set in advance for the reimbursement of different categories of medical service provider (e.g., physicians, hospitals, nursing homes, etc.).
- Reimbursement to individual providers should be based on the actual or average cost of the resources consumed in providing a service (existing systems of reimbursement could be selected, although not necessarily).
- All reimbursement should be made in a timely fashion by the appropriate administrative agency. Additional payments beyond amounts allowable by the administrative agency should not be permitted. We remain open to the issue of co-payments, deductibles, and coinsurance based on further research provided that such payments do not hinder timely access to appropriate and necessary services.
- Neither a retrospective, charge-based reimbursement system, nor a system in which all providers are employees of the National Medical Plan, is advisable.

Reimbursement refers to the methods that are used to pay providers for the services they render.

Resource Development and Delivery System Structure

Definition: Resource development refers to creating the capital, labor, and knowledge assets required to produce high quality, cost-effective medical services. Delivery system structure refers to the ways in which medical services are organized and made available to consumers, and the ways in which these resources are utilized to produce the desired medical services.

Basic Principles:

- The National Medical Plan needs to promote the development of the capital (e.g., medical facilities), labor (e.g., health personnel), knowledge (e.g., health services research and biomedical research), and technological resources (e.g., equipment, drugs, etc.) required to deliver, manage, and improve medical care services.
- A National Medical Plan should afford the greatest possible opportunity for innovation and creativity in the design, organization, and delivery of medical care services.
- Public and private agencies periodically should compete for the right to provide medical services as part of the National Medical Plan based on the cost, quality, and accessibility of their services.
- Emphasis should be given to the development and use of rational and humane methods for coordinating and managing the delivery of medical care services.

Policy and Administration

Definition: Policy and administration refers to the development of policy for the National Medical

Plan, the management of the National Medical Plan, and participation in decision making regarding the National Medical Plan.

Basic Principles:

- Policies for the National Medical Plan should be set at the national level to assure broad-based consensus in the development of policies and equality of application of the policies that are adopted.
- Public and private agencies periodically should compete for the right to administer the plan based on the costs of administration and responsiveness to consumer, provider, and payer concerns.
- A national uniform data and information system should be established and maintained with respect to the planning, operation, and evaluation of the National Medical Plan including demographic, epidemiologic, financial, and quality information in a manner that does not jeopardize privacy rights of individuals.
- The views and concerns of consumers, providers, and payers should be represented at all levels and in all stages of the policy and administrative systems.

Assessment and Assurance of Quality

Definition: Assessment and assurance of quality refers to the standards that are established for the safety, efficacy, and outcomes of medical service use, and the methods employed to assure the quality of the services provided.

The National Medical Plan needs to promote the development of the capital, labor, knowledge, and technological resources required to deliver, manage, and improve medical care services.

Basic Principles:

- Quality refers to the efficacy, effectiveness, appropriateness, and timeliness of the health services provided.
- A uniform national standard for the quality of health services should be established.
- To the extent feasible, quality assessment and assurance should be based as much on the outcomes of the services provided as on the technical structure and process of delivering the services. "Outcomes" include physiological status, functional ability, quality of life, and satisfaction with care for both consumers and providers.
- Assessments of quality should take account of both consumer and provider views.
- Methods for assuring the quality of care should be designed to promote continuous quality improvement.
- Consumers and providers should be provided regularly with information about the quality of medical services delivered and with education about how to use this information.
- A uniform national data reporting system on the quality of medical services should be established and made a part of the National Medical Plan as described above, under the section on Policy and Administration.

Management of Use

Definition: Management of use refers to the limits or controls that are established on the use of medical services by consumers and providers.

Basic Principles:

- Management controls need to be designed to reflect the values of stewardship described above, to assure that services are provided in a timely fashion, and to assure that only those services that are both appropriate and necessary are provided.
- Any system of management control should give emphasis to the development and incorporation of rational and humane methods for coordinating and administering the delivery of medical care services.
- Consumers and providers should be provided with ongoing education and information about how best to utilize the health system.
- Because insufficient resources exist to offer all possible medical services, prioritization of services to be made available as part of a National Medical Plan will be necessary.

Cost Containment

Definition: Cost containment refers to controlling the total expenditures made for the provision of medical services.

Basic Principles:

- Cost control is an activity that must occur at every level of the medical care system to be effective.
- Consumers and providers must both share some financial risk in order to promote efficient use of medical resources. The financial risk, however, must not interfere with the timely provision and use of necessary and appropriate medical services.
- Cost containment and quality assurance efforts must be closely linked.

Cost containment and quality assurance efforts must be closely linked.

A uniform national standard for the quality of health services should be established.

- Cost containment begins with an appropriate selection of benefits to be provided as part of a National Medical Plan, and continues through the specification of a fair financing system, implementation of an effective reimbursement system, developing an appropriate structure for the delivery of medical services, and creating adequate systems for the assurance of quality and management of the use of medical services.

Choice

Definition: Choice refers to the opportunities for both consumers and providers to have some measure of autonomy in their respective roles.

Basic Principles:

- Consumers should have reasonable choice in the selection of the provider whom they wish to use and the service they will receive.
- Providers should have reasonable choice over the individuals they wish to serve and the services they wish to provide.
- Some limitation on patient freedom of choice and provider autonomy may be necessary in the interest of efficiency and equity within the National Medical Plan.
- Under no circumstances should race, creed, ethnic origin, or economic class be used in limiting the choice or the autonomy of patients or providers.

Linkages

Definition: Linkage refers to the connections between the medical care system, the larger health system, and other social service systems such as welfare, housing, income, employment, and

education that affect the health and the quality of life of the public.

Basic Principles:

- Recognizing the inherent interrelatedness of health status with other social conditions and problems, a National Medical Plan must be conceptually and organizationally linked to other social service systems (such as welfare, housing, income, employment, education, and the religious community) that bear on the prevention of health problems, the effectiveness of medical treatment, and the speed of recovery and rehabilitation from health problems.
- An appropriate balance should be struck between the objectives for the medical system of prevention, treatment, and rehabilitation.

Transition

Definition: Transition refers to the political and administrative process of moving from the current ways of organizing, financing, and delivering medical services to a system that would be created based on the principles enunciated in this statement.

Basic Principles:

- The transition should be made as expeditiously as possible.
- The first priority should be to provide coverage for those who currently are without any medical service protection.
- The second priority should be to provide coverage for those who currently are without adequate medical service protection (e.g.,

A National Medical Plan must be conceptually and organizationally linked to other social service systems.

those without sufficient medical insurance or financial resources in relation to medical expenses and needs).

ENDNOTES

1. The Pepper Commission, *A Call for Action: An Executive Summary* (Washington, D.C.: U.S. Government Printing Office, 1990), 2.

2. National Health Care Campaign, *National Health Care: An American Priority* (Washington, D.C., 1990), 3.

3. A recent Families USA Foundation Report confirms that the "Joint Economic Committee estimates the number of underinsured at 70 million. See Medical Alert, a staff report of the Subcommittee on Education and Health of the Joint Economic Committee, October 1989." See Families USA Foundation, *Emergency! Rising Health Costs in America 1980-1990-2000* (Washington, D.C., 1990), 6.

4. See Jim McDermott, "The Health Care Crisis: What Remedies Make the Most Sense?" *News from Congressman Jim McDermott* (March 19, 1990): 2.

5. Quoted by Senator Edward M. Kennedy during a statement to the Subcommittee on Health for Families and the Uninsured of the Senate Finance Committee. See United Church of Christ Office for Church in Society, *A Proposal for Action on Toward an Accessible Universal Health Care System* (Washington, D.C., 1990), 2.

6. See The Pepper Commission U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action: Executive Summary* (Washington, D.C.: U.S. Government Printing Office, 1990), 1.

7. Nilson Report on Bankruptcy, October 14, 1988. See United Church of Christ Office for Church in Society, *A Proposal for Action on Toward an Accessible Universal Health Care System*, (Washington, D.C., 1990).

8. *The Washington Post* (December 21, 1990): 83. See also projections by the Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, "National Health Expenditures, 1986-2000." *Health Care Financing Review* 8, (no. 4, 1987): 1-36.

9. R.J. Blendon and H. Taylor, "View on Health Care: Public Opinion in Three Nations." *Health Affairs* 8 (1989): 149-57. Found in Robert J. Blendon and Karen Donelan, "The Public and Emerging Debate Over National Health Insurance." *New England Journal of Medicine* 323 (July 19, 1990): 209.

10. See notes eleven and twelve, below.

11. *Universal Access to Health Care: An Emerging Issue Paper*, commended to the church for study and comment by the 202nd General Assembly (1990) (Louisville: Office of the General Assembly, Presbyterian Church (U.S.A.), 1990).

12. *Life Abundant: Values, Choices and Health Care: The Responsibility and Role of the Presbyterian Church (U.S.A.)* (Louisville: Office of the General Assembly, Presbyterian Church (U.S.A.), 1988). See also, Walter E. Wiest, editor, *Health Care and Its Costs: A Challenge for the Church*, (Lanham, Mass.: University Press of America, 1988).

13. *Minutes of the 158th General Assembly* (Philadelphia: Office of the General Assembly, Presbyterian Church in the United States of America,

14. "The Relationship of Christian Faith to Health." *Minutes of the 172nd General Assembly* (New York: Office of the General Assembly, United Presbyterian Church in the United States of America [UPCUSA], 1960), 285.

15. *Ibid.*, 286.

16. *Minutes of the 173rd General Assembly* (New York: Office of the General Assembly, UPCUSA, 1961), 450.

17. *Minutes of the 175th General Assembly* (New York: Office of the General Assembly, UPCUSA, 1963), 327.

18. *Minutes of the 180th General Assembly* (New York: Office of the General Assembly, UPCUSA, 1968), 387.

19. *Minutes of the 181st General Assembly* (New York: Office of the General Assembly, UPCUSA, 1969), 755.

20. *Health Care: Perspective on the Church's Responsibility* (Atlanta: Office of the General Assembly, Presbyterian Church in the United States, 1976), 1.

21. *Life Abundant: Values, Choices and Health Care* (Louisville: Office of the General Assembly, Presbyterian Church (U.S.A.) [PC(USA)] 1988), 13.

22. *Minutes of the 183rd General Assembly* (New York: Office of the General Assembly, UPCUSA, 1971), 588 *Life Abundant: Values, Choices and Health Care* (Louisville: Office of the General Assembly, PC(USA), 1988), 28.

23. *Life Abundant: Values, Choices and Health Care* (Louisville: Office of the General Assembly, PC(USA), 1988), 3-4.

24. *Life Abundant: Values, Choices and Health Care* (Louisville: Office of the General Assembly, PC(USA), 1988), 29.

25. *Minutes of the 183rd General Assembly* (New York: Office of the General Assembly, UPCUSA, 1971), 586.

26. *Life Abundant: Values, Choices and Health Care* (Louisville: Office of the General Assembly, PC(USA), 1988), 28.

27. This theme is common to all of the above listed General Assembly statements.

28. See the above referenced works plus the following:

Minutes of the 186th General Assembly (New York: Office of the General Assembly, UPCUSA, 1974), 199.

The Provision of Health Care: Obedience to Divine Purpose (New York: Office of the General Assembly, PC(USA), 1983).

29. "The Relationship of Christian Faith to Health." *Minutes of the 172nd General Assembly* (New York: Office of the General Assembly, UPCUSA, 1960), 284.

Study Guide for Christian Responsibility and a National Medical Plan

Purpose

This guide is written to accompany *Christian Responsibility and a National Medical Plan*, a resolution of the 203rd General Assembly (1991). The guide offers a time-limited process to study the document. It will help participants, either as individuals or in groups, act on the recommendations of the resolution. It provides timely information, informs the conscience about the issue, and invites participants to engage in advocacy and action toward solving the problem.

Preparing for the Study

The time allotted for this study will depend upon the size and purpose of the group. This guide shows how to study the document in two short-term periods, but it also indicates how to expand the time periods for a more complete study of the complex issues of health care and a national medical plan. The leader should decide how much time and how many sessions will be used.

Each member of the group should receive a copy of the resolution in advance of the first study session. If the leader has chosen the minimum two-session study, it will be important to make the assignments suggested below in "Study Session One" before class begins. In an adult series, assignments could be handed out during the first session.

Study Session One: Introduction and Perspective

Purpose of the Session

- To become aware of the impact of the national health crisis on our own lives, families, and communities; and
- To gain understanding of a biblical and theological approach to establishing a national medical plan.

Preparation

- Before the first class, distribute one copy of *Christian Responsibility and a National Medical Plan* to each person so that it may

be read prior to the first meeting. Attach a memo to the resolution that asks participants to be responsible for preparing the following:

- (1) A personal or news story that illustrates the problems with medical care costs, payment, insurance, or the uses and delivery of services. The closer to "home," the better. (The resolution lists some of these problems as it acknowledges the statistics about our medical care. The story of the woman trapped by her medical benefits package is an example.)
 - (2) Assign each person to read, and be ready to talk about, one of the five characteristics of the Christian perspective (Caring; Doing Justice; Preventing, Curing, and Building Community; Stewardship; and Community). Persons assigned to each item might want to talk together before the meeting and agree on what to share with the whole group.
- Look ahead to the preparation section of the next session.
 - Have in the room newsprint or a blackboard for use during the study session.
 - Write on the board or newsprint (to be uncovered at an appropriate time): "Our health care system is not very healthy, it is not caring, and it certainly is not a system."

Study Session Agenda and Methods

Opening and Introduction (10-15 Minutes)

Begin with prayer and a Scripture reading (e.g., selections from Matthew 8:1 to 9:34 showing our tradition of faith and wholeness).

Make sure the members know each other by name. If this is an ongoing group in the church, take three to five minutes to greet each other and become focused within the group. If this is a new group, spend a limited time (ten minutes) with brief introductions (name tags will help).

State the purpose and focus of the study time (as found in the "Purpose" and "Preparation" paragraphs above).

Stating and Illustrating the Problem (15-20 Minutes)

Uncover the statement written on the blackboard or newsprint. Tell the group that this statement is loosely attributed to Walter Cronkite in an extensive documentary on how America provides medical treatment. Point out how close this is to the assessment in the third paragraph of the resolution (p. 2). Ask the group to briefly share their own personal or news stories that illustrate the problem (not healthy, not caring, not a system, inequitable, too costly).

It may be true that a particular Presbyterian church or group has had consistently good experiences with medical treatment, costs, and delivery. Unfortunately, such a sheltered group may not be able to understand our nation's health care problem. The leader will want to use this time to help the group see connections among individual, community, state, and national problems. Not everyone has been blessed with excellent access to medical care.

Summarize this sharing by pointing to the need for systematic reform rather than adjusting the elements, which is what has been done in the past.

Establishing a Christian Perspective (30 Minutes)

Begin this part of the session by pointing to the long-term interest of the Presbyterian church in this issue. Use the earlier statement of the 158th General Assembly (1946). Move on to the current 1991 document. Quotations in the documents from previous General Assemblies can briefly illustrate this history of engagement. Then, point out the need to move toward a theological view that challenges the secular and cultural values currently allowing us to deny sustainable access to health care for many of our citizens.

Ask for a brief statement or presentation from the persons assigned to each of the five characteristics of a Christian perspective:

Caring,
Doing Justice,
Preventing, Curing, and Building Community,
Stewardship, and
Community.

Use the blackboard or newsprint to highlight words and phrases that capture the meaning of these characteristics. When all five

values have been stated, ask the group for questions and discuss in depth their meaning.

Some members of the group may express an individualism that keeps illness, costs, and benefits private, while resisting shared community responsibility. This viewpoint may underlie the discussion on each of the five characteristics. Our current "non-system" is aided and abetted by individualism. It is a primary value underlying the status quo that is challenged by *Christian Responsibility and a National Medical Plan*.

Summarize the class period by highlighting the statement of the problem and its personal and national impact. Review the biblical and theological roots of Presbyterian policy and the historic response of the church. The Presbyterian community stands for a responsible health care system; a system inspired by values that sustain the dignity of life and the fullness of community.

Study Session Two: Working Together for Change

Purpose

- To understand the elements that should be included in an ethically and theologically informed national medical plan; and
- To develop a personal and/or group commitment to act upon the pertinent recommendations of the General Assembly for action and advocacy.

Preparation

At the end of the previous session, the leader should ask for volunteer teams to focus on three or four of the thirteen elements and principles of a national health plan. The assignment is to read each one and to state and present briefly each element to the group. People's statements should reflect their own words and understanding. Team members may need to discuss these ahead of time to clarify the meaning of the elements.

- Have newsprint or a blackboard available for use.
- Prior to class, write the following on the board or newsprint: "Is health care like any other commodity, to be distributed as a reward for achievement?" (*Christian Responsibility and a National Medical Plan*, first paragraph, p. 23.)
- As class begins, distribute copies of Appendix A.

Study Session: Agenda and Methods

Opening and Introduction (10-15 Minutes)

Begin with prayer and a Scripture reading that shows the church as a place of healing (e.g., Luke 9:1-6; Acts 3:1-10; 5:12-16; James 5:13-16).

Introduce the topic with a brief summary of the previous session. Uncover the statement written before class and read it. Invite individuals to respond to the statement. You may want to distinguish responses affirming common, cost/benefit values from values that affirm personal dignity within the setting of a responsive community.

Stating the Basis for a Responsible National Medical Plan (15-25 Minutes)

Have the assigned class members briefly state and explain each of the thirteen elements that inform a good national medical plan. The group may ask questions for clarification and understanding; but if time is a factor, the leader may wish to hold discussion until after each group has presented its report.

Some of these elements will raise more concern and discussion than others. Focus on them, and use the preceding session on values to inform the current discussion on the meaning and importance of each element. The practical politics of designing a particular plan is not the issue or debate; the issue is determining what criteria would inform and structure such a plan.

Once all items have been presented and a reasonable time for clarification and discussion has been given, summarize and move on.

Making a Commitment to Respond (15-30 Minutes)

Have the group turn in their copies of the resolution to pages 5-6 and read recommendations j, k, and l. Each of these addresses the local church and individual members of the church.

Hand out Appendix A, "Thinking About Mission." Help the group understand the handout's format. The three mission functions are:

Study	Something your class is doing;
Advocacy	Speaking truth to power, writing Congress, and so forth; and
Social action	Salving wounds, creating soup kitchens, and so forth.

Opportunities for participants to think about each governing body of the church are provided. An "altar call"—an opportunity for each individual to design a work plan and commit his or her time—is provided as well.

You should give your group a chance to think silently, then you should invite public responses. Have the members share their answers to each of the three questions. Note the comments on the board or newsprint. If your group is typical, it will generate many answers. Consensus, however, may not be apparent. That is fine. Affirm each action and encourage participants to "do it!"

After receiving responses, ask the group to identify common themes. Consensus or agreement may emerge. This is your real goal: personal and corporate responses that ultimately lead to action. If the group needs more time (and if there is a reasonable expectation that consensus can develop at a later time), suggest another meeting (limit the time for this). Members of your session and/or the pastoral staff may want to attend.

One final piece of advice: Do not give in easily to the tendency to do nothing. Many of us are overwhelmed with work, family, church, and other activities. However, our "non-system" of health care won't be changed without informed, committed, Christian people who are willing to do something.

Extended or Longer Study Sessions

Study Sessions: Introduction and Perspective

Stating and Illustrating the Problem

Ask persons in the group to gather and to report information collected from local doctors, clinics, and hospitals regarding: uninsured patients and under what circumstances they may or may not be treated; how many patients (numbers or percentage) are not insured; how much of the charges (dollars or percentage) is not recovered because of bad debt, and how much is not recovered due

to charity; how many doctors or clinics (and maybe which ones) do not take Medicaid; how many doctors (and maybe which ones) take a Medicare assignment for payment without additional charges to the patient; and how many hospitals have closed within the community or state during the past five years.

You may assign several persons to devise a brief questionnaire for your congregation (and even other nearby congregations) that would ask members (anonymously) for the following information: age; sex; how they are insured medically (by private insurers, employers, Medicare or Medicaid, or uninsured); if they have had difficulty getting a doctor, clinic, or hospital; an estimate of their yearly out-of-pocket expenses for health care (percentage of income would be the best way to get an answer); whether persons have had difficulty either becoming insured or transferring to a different insurance plan; how many days were lost from work in the past two years due to health problems; how much time was spent in the hospital in the past two years; if they have seen a doctor in the past year for a physical exam or check-up other than for an illness; and if they have been told to leave a hospital before they were ready because their medical coverage ran out.

Class time can be structured (two to three sessions) to hear reports on the data gathered from local health providers and individuals. Look at the problems of medical treatment and care from the perspectives set out in the opening sections of the resolution (two conditions that lead to difficulty in getting care are lower income and age). When this information is reported, the group will have valuable insight into the problems of the local community. This will lay a solid basis for advocacy and action. Gathering data is the first step toward action.

Establishing a Christian Perspective

Use additional sessions to focus on each of the five characteristics; allot time for discussion of each one. Each characteristic carries tension with current secular values within it. Discuss this tension. Statements that illustrate this tension might be:

Caring—"Caring is imperative even when curing is not possible"; "When we exclude persons from access to health care, we render bankrupt our witness to the God who never abandons anyone in the margin" (p. 14).

Doing Justice—"This understanding of justice stands in sharp contrast to the two views of justice in our society that dominate discussions of who is to get how much and what kind of medical care" (p. 15). (This is the "bottom line" notion of justice). "A Christian view of justice challenges a pluralistic and secular society to affirm the interdependence of all members of the community" (p. 16).

Preventing, Curing, and Building Community—"When persons are excluded from health care, they are in effect being told that their uniqueness is not valued and their contributions to the well-being of the larger community are less important" (p. 17).

Stewardship—"If society has no sense of purpose for health care, it exercises no stewardship. It is forced to limit, cut back, and ration health care in an often irrational or unjust way" (p. 18).

Community—"Illness is not the burden of the ill alone, nor is caring, which is the expression of divine care, the calling of health professionals alone. It is appropriate that the costs of health care be shared by the whole population" (p. 19).

Making a Commitment to Respond

If your group has not done any of the extended activities of gathering data as indicated in the above "Extended Session," this would be an appropriate time to do this. These kinds of local details and real-life stories will give you and your church the information needed to develop plans for personal and corporate action.

If your group has already collected this information, now is the time to use it to give you or your church direction for action. Look for the problems of access to health care, the lack of availability of health services, inadequate services, groups that are underserved, and problems that do not seem to be addressed by the health care providers in your locale.

After reviewing the data in this fashion, plans can be made for both advocacy and action. Your church or group may want to work to provide some form of health care (transportation, parish nurse, church-sponsored clinic, services to the elderly, well-baby checks, health fairs, and health screening). Another step is to become advocates for improving (or changing) the system locally, at the state level, and at the federal level. Develop a plan to inform church

members of the issues that have been studied, and how the members may be enlisted to participate with you and your group in advocacy.

This Study Guide was prepared by Kent Miller, chairperson of the Presbyterian Health Network, for the Committee on Social Witness Policy, Fall 1991, for the resolution, *Christian Responsibility and a National Medical Plan*. This resolution was adopted by the 203rd General Assembly (1991) of the Presbyterian Church (U.S.A.), at its meeting in Baltimore, Maryland, June 1991.

APPENDIX A

THINKING ABOUT MISSION

WHAT?	WHO?	How?
Study	General Assembly Synod Sessions Committees/Classes Members	
Advocacy	General Assembly Synod Sessions Committees/Classes Members	
Social Action	General Assembly Synod Sessions Committees/Classes Members	

Moving toward commitment

As an individual, I can and will do the following:

As a church, I recommend we do the following:

Committees or groups in the church can be asked to do the following: