Standing Commission on Health

MEMBERSHIP

Bishops
Robert W. Ihloff (Maryland) *1997* replaced
William E. Smalley (Kansas)
Thomas C. Ray (Northern Michigan) *2000*
Presbyters
Ran Chase (Massachusetts) *1997, Executive Council Liaison*
Carol Cole Flanagan (Maryland) *1997, Chair*
Lay Persons
Hope Hendricks Bacon, M.A., CC-SLP (Los Angeles) *1997, Secretary*
Thomas R. Bates, M.D. (Central Florida) *2000, Treasurer*
Nancy B. Cummings, M.D. (Washington) *1997, Vice Chair*
John E. Fryer, M.D. (Pennsylvania) *2000*
Richard Ko, Pharm. D., Ph.D. (Northern California) *2000*
Robert Brooks, *ECC Staff Liaison*

Commission representatives at General Convention:
Bishop Robert W. Ihloff and Deputy Thomas R. Bates are authorized to receive non-substantive amendments to this report.

SUMMARY OF THE COMMISSION'S WORK

The Standing Commission on Health is charged "to study and concern itself with the theological, ethical and pastoral questions inherent in the subjects considered by the Commission" (Canon I.1.2(n)(4). During this triennium, our church and society were challenged by massive changes in the health care system, and new ethical and pastoral questions. In the midst of this transition, health care is still a rapidly "moving target" and difficult to study. The social contract of the past has disintegrated, and a new social contract has yet to emerge with any clarity. Rather than addressing new technological developments, or discrete ethical and pastoral issues, such as physician-assisted dying, the commission undertook to gather information and to prepare the ground for an examination and study of the role of the church in the new order.

It appears that our society is ambivalent about our health care system. While many members of our society have lost confidence in the ability of our institutions, whether public or private, to meet the compelling needs of our communities, polls show that sixty to seventy percent of Americans express a degree of satisfaction with our personal health care. There is a marked disparity in the provision of health care to different groups in our society. It is well known that the United States has the highest quality of medical care in the world, but that many of our people do not even have adequate primary medical care. Evidence of this situation includes:

Limited Governmental Resources - Federal, state and local funds are stretched, and health care needs continue to grow. The shifting of responsibilities from one jurisdiction to another, (i.e.

from federal to state, or state to local agencies) does not provide a solution to the problems, nor is it possible simply to pass these responsibilities on to the private sector.

Failure of Will for Universal Health Care - Universal health care is one of the principles adopted by the 71st General Convention of the Episcopal Church. While there have been efforts by the federal government to develop a program for universal health care reform in the recent past, the electorate and the health care and insurance industries have supported, and continue to support, only incremental reform.

Undercoverage - The Employee Benefit and Research Institute (EBRI) reported in 1995 that 40.9 million of the civilian nonelderly population under age 65 in 1992 were uninsured for health. It is widely reported that a similar number are inadequately insured. Of those who are uninsured, 55.5% are working adults and 27.2% are children. This number has been increasing substantially in recent years.

The problems given here are only a few of the signs of the challenges facing our church and society. These signs speak to a much deeper and more pervasive issue. That issue is that we, in our society, have come to see health care as a product which is entrepreneurial and employer based. In these latter years of the century and the millennium, health care has moved even further into a for-profit model. Medical treatment and policy are increasingly determined by profit principles rather than by Christian principles, or compassion. Managed care is only the outward and visible sign of a health care system which is perceived as bloated, inefficient, and too expensive. Business has taken major initiatives, with little regard for the necessity to provide health care for the entire population. As a Christian community, we must move to enact the faith imperatives to love our neighbors, to show mercy, to heal the sick, and to seek and serve Christ in all persons.

This mandate is expressed compellingly in many sections of Scripture, but nowhere more so than in the parable of the Good Samaritan. This parable has had a major influence on the compassionate care of the ill, the injured, and those in need of care throughout the history of western civilization. The Royal Hospital of St. Bartholomew, established in London in 1123, has a mural in its Great Hall painted by Hogarth which illustrates this parable. The words of the parable, "Take care of him and I will repay thee" are the motto of Pennsylvania Hospital, the oldest hospital in the United States, founded by Benjamin Franklin in 1751.

In the past, the Episcopal Church, as well as many other religious and charitable organizations, have established hospitals as an expression of their mission and ministry of healing. Many of these hospitals have since been acquired by "for profit" corporations, or have been absorbed into much larger health care systems where profit has become the prime motive for their existence. It is ironic that both St. Bartholomew's in London, and Pennsylvania Hospital in Philadelphia have become part of such conglomerates in recent years. This trend presents a substantial challenge to the church.

The early church had a rich concept of orders within the baptismal community: catechumens, candidates for baptism, penitents, widows, the sick, as well as bishops, priests, and deacons. The Paschal passage of Jesus from life to death to burial to resurrection was embodied in a different way in each of these orders of the baptized. The sick could be seen as a sign of the suffering Christ who, through that suffering, passes to new life. Anointing the sick heightened the

connection to baptismal chrismation and the continuing Christ-presence/passage through those who were sick among the faithful. The sick were given a special place within the worshipping community, which was relinquished upon their restoration to health. Deacons visited the sick as did catechumens, so that those coming to baptism encountered Christ among and through the sick and suffering.

As the catechumenate declined after Constantine's Edict of Toleration in 313 A.D., many Christians desired to maintain the ethos that previously characterized faith communities by founding religious orders. One of the aspects of baptismal ministry they preserved was ministry with the sick. Religious houses soon became centers for the care of the sick, and those centers have evolved through the centuries into what we now know as hospitals.

In our own time, the rite used by lay eucharistic ministers for visiting the sick manifests the insights of the early church's baptismal community. Those who are sick or infirm are seen as embodiments of Jesus' Paschal passage who minister Christ's continuing presence to the local congregation. That is why they are invited to comment on the scripture and to voice their own prayer, thereby proclaiming the gospel and exercising their intercessory priestly office to their congregation through the lay eucharistic minister and others present. Rather than passive recipients of sacraments, those who are sick or infirm are living, active epiphanies of the victorious passage of Jesus through suffering to wholeness and new life.

The Episcopal Church, through the ministry of its members, its congregations and dioceses, and its General Convention, has a vocation to health care. In our nation, standards for health care are developed and refined through constant dialogue, and in some cases established through legislative action and interpreted by the courts. Our church is called to take its place in this dialogue, and to minister to the sick and infirm in the changing health care environment.

Our neighbor, Canada, has approached health care from a perspective which differs from ours. Sociologists have described these differences and noted that whereas we tend to be individualistic, Canadians tend to be more communitarian. This has led Canada to develop a social insurance system which contrasts sharply with the private sector model of the U.S. The Canadian system considers health care as a social good and offers medical care to all citizens regardless of ability to pay. Our system considers health care as a social product to be purchased by those who can afford to pay for it. Like many high income, industrialized countries, both Canada and the United States perceive difficulties with their current systems and search for methods to improve the delivery of health care.

In 1994, the 71st General Convention adopted the following health care principles (A057a):

- that universal access to quality, cost-effective, health care services be considered necessary for everyone in the population;
- that "quality health care" be defined so as to include programs in preventive medicine, where wellness is the first priority;
- that "quality health care" include interdisciplinary and interprofessional components to insure the care of the whole person – physiological, spiritual, psychological, social; and
- that "quality health care" include the balanced distribution of resources so that no region of the country is underserved.

Among the changes in the character of health care delivery is the increase in the number of persons covered by managed care or health maintenance organizations (HMOs). Enrollees in HMOs increased from 6 million in 1976 to 53.3 million in 1995, and are projected to reach 103.2 million by the year 2000. Managed care is a system which emphasizes social control through organized competition. Managed care encourages providers and hospitals to form networks and requires accountability from health care professionals, doctors, hospitals, pharmaceutical companies, and manufacturers of medical devices. Under managed care, the delivery of health care is not being decided by those with the greatest knowledge of the patients, their illnesses, and their needs, but by administrators whose primary allegiance is to all of the enrollees in the system rather than to the individual patient. Major moral and ethical concerns are that the disenfranchised -- the elderly and the uninsured -- will not receive equal and adequate care through the managed care networks.

In the private sector, the restructuring of the health care system is moving from a fragmented and pluralistic structure to a consolidated one; from payment by fee-for-service to capitation, and from a system dominated by the provider of health care to a system dominated by the buyer, who is frequently a third-party payer. On the one hand, these systems have produced numerous cost-cutting measures. On the other hand, these are achieved by hospital stays that are shortened stringently, by restricting care, such as limiting the number of visits for the treatment of mental illnesses, or by limiting the discussion with patients of treatment options deemed too expensive. A physician under contract may be restricted in the information he or she is permitted to supply to patients. Similarly, patients can no longer depend on physicians to act in the patient's best interest if the physicians' first obligation is to the organization or system with whom they are under contract.

In our society, medical care has focused on the treatment of disease rather than on health, its maintenance, and the prevention of disease. If we are to seek and serve Christ in all persons, and respect the dignity of every human being, then all in our society must have access to primary health care as a minimum standard. Health is only one of the social goods (health, welfare, housing, education, cultural activities, defense, police and fire protection) which compete for funding, both public and private. Primary health care, which is covered in the essential elements of health outlined by the World Health Organization in 1977 includes:

- adequate food and housing;
- protection of houses against insects and rodents;
- water adequate to permit cleanliness and safe drinking;
- suitable waste disposal;
- services for provision of antenatal, natal and postnatal care;
- family planning, infant and childhood care, including nutritional support; and
- immunization against the major infectious diseases of childhood.

To the Rich Young Ruler, Jesus said, "You shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and your neighbor as yourself." He offered the parable of the Good Samaritan to indicate who our neighbor is, and said to our ancestors and to us, "Go and do likewise."

FINANCIAL REPORT FOR THE 1995-97 TRIENNIUM

	1995	*1996*	*1997*
Income	$15,136	$14,135	$729
Expenses			
Administrative	$219	$274	$200
Commission Meetings	7,460	16,885	400 *
Subcommittee Meetings	1,631		
Totals	$9,310	$17,159	$600 *

* estimated

GOALS AND OBJECTIVES FOR THE COMING TRIENNIUM

To advance the mission of the church in the health care arena, the Standing Commission on Health recommends that we continue to work with a wide variety of denominations and faith groups, professional societies, health care organizations and networks, labor unions and consumer groups – all of the stakeholders engaged in the ministry of healing. During the next triennium, there will be material published by the National Coalition on Health Care and other partners suitable for study by congregations and dioceses. Our goal for the next triennium is to produce a theological introduction and study guide for use with this material to assist us in an examination of the role of the church in the new health care environment. We are requesting an additional $5,000 to engage a consultant/educator for this work, which can be made available to all congregations. We believe a re-examination of the role of the church in a time of such transition is a necessary step as we strive to pursue our vocation as the church and secure adequate health care for all in our society.

BUDGET APPROPRIATION

	1998	*1999*	*2000*
Expenses			
Consultants	$2,500	$2,500	-
Administration	250	250	200
Commission Meetings	15,000	15,000	-
Subcommittee Meetings	1,000	1,000	-
Total	$18,750	$18,750	$200

RESOLUTIONS

Resolution A058 Standing Commission on Health Budget Appropriation

Resolved, the House of _____ concurring, That the sum of $37,700 be appropriated for the work of the Standing Commission on Health during the next triennium.

Resolution A059 Standing Commission on Health Study Guide

Resolved, the House of _____ concurring, That the 72nd General Convention of the Episcopal Church authorize the Standing Commission on Health to produce a theological introduction and study guide on the changing role of the church in the new health care environment, which could be made available to all congregations; and to seek the services of a consultant/educator for this project.

Resolution A060 Commend Governmental Relations Office and the Public Policy Network

Resolved, the House of _____ concurring, That the 72nd General Convention of the Episcopal Church commend the work of the Governmental Relations Office and the Public Policy Network for their direct service to grassroots groups in our congregations and dioceses which equips and enables them to advance the mission of the church in the world.